

CONTRACT #14
RFS # 318.66-026

Department of F&A
Bureau of TennCare

VENDOR:
Volunteer State Health Plan,
Inc. (TennCare Select)

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED

RECEIVED

JUN 09 2006

Commissioner of Finance & Administration

Date:

FISCAL REVIEW

Each of the request items below indicates specific information that must be individually detailed or addressed as required.
 A REQUEST CAN NOT BE CONSIDERED IF INFORMATION PROVIDED IS INCOMPLETE, NON-RESPONSIVE, OR DOES NOT
 CLEARLY ADDRESS EACH OF THE REQUIREMENTS INDIVIDUALLY AS REQUIRED.

RFS #	318.66-026		
STATE AGENCY NAME :	Department of Finance and Administration, Bureau of TennCare		
SERVICE CAPTION :	Provides TennCare covered services to children in State custody and provides a safety net should other MCO's fail.		
CONTRACT #	FA-02-14632-00	PROPOSED AMENDMENT #	15
CONTRACTOR :	Volunteer State Health Plan, Inc.		
CONTRACT START DATE :	July 1, 2001		
CURRENT, LATEST POSSIBLE END DATE : (including ALL options to extend)	12/31/2006		
CURRENT MAXIMUM LIABILITY :	\$464,688,530.90		
LATEST POSSIBLE END DATE WITH PROPOSED AMENDMENT : (including ALL options to extend)	12/31/2006		
TOTAL MAXIMUM COST WITH PROPOSED AMENDMENT : (including ALL options to extend)	\$510,025,427.90		
APPROVAL CRITERIA : (select one)	<input checked="" type="checkbox"/> use of Non-Competitive Negotiation is in the best interest of the state <input type="checkbox"/> only one uniquely qualified service provider able to provide the service		
ADDITIONAL REQUIRED REQUEST DETAILS BELOW (address each item immediately following the requirement text)			
(1) description of the proposed additional service and amendment effects :			

This amendment provides modifications to MCO language including: (1) Fraud and Abuse clarification regarding MCOs investigative work in conjunction with the Office of Inspector General; (2) Redefine targets to move away from trends and provide consistent benchmarks among MCOs, including increasing EPSDT benchmark to 80; (3) Modify Credentialing to 30 day performance standard from receipt of completed application for reviewing and loading into system; add LD for non-compliance; (4) Revise Liquidated Damages to add specific LDs, clarify language of compliance with notice requirements vs. appeals, and provide consistency with Middle TN RFP Pro Forma; (5) Update benefit package to reflect current requirements for July 1 including soft limits and cost effective use of Chiropractic services; (6) Update Appeal language to reflect recent Grier filings; (7) Revise provider payment requirement to reflect current operations, TPL, Utilization Summaries and 1099; (8) Make revisions for consistency throughout the Agreement, including EPSDT, Provider Agreement, and Reporting; and (9) Provide funding to continue services for additional six month period.

(2) explanation of need for the proposed amendment :

This amendment is needed to make above modifications as well as provide funding for additional six month period.

(3) name and address of the proposed contractor's principal owner(s) :
(not required if proposed contractor is a state education institution)

BlueCross BlueShield 801 Pine St Chattanooga, TN 37402

(4) documentation of OIR endorsement of the Non-Competitive procurement request :
(required only if the subject service involves information technology)

select one:



Documentation Not Applicable to this Request



Documentation Attached to this Request

(5) documentation of Department of Personnel endorsement of the Non-Competitive procurement request :
(required only if the subject service involves training for state employees)

select one:



Documentation Not Applicable to this Request



Documentation Attached to this Request

(6) description of procuring agency efforts to identify reasonable, competitive, procurement alternatives rather than to use non-competitive negotiation :

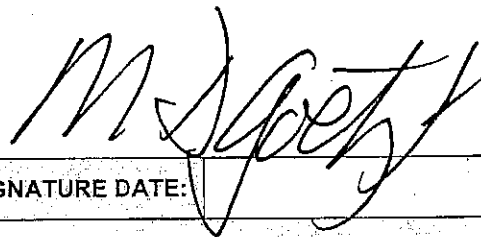
This Contractor is currently providing a network of services for the TennCare Program. This is an amendment to current contract.

(7) justification of why the F&A Commissioner should approve a Non-Competitive Amendment :

The Bureau of TennCare is currently modifying all of the MCO contracts to provide specific language changes for clarity and compliance with current changes in the TennCare program. These MCO contracts provide necessary Health Care Services to the TennCare/Medicaid Population and TennCare would greatly appreciate approval by the Commissioner of F&A.


AGENCY HEAD REQUEST SIGNATURE:

(must be signed by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR — signature by an authorized signatory will be accepted only in documented exigent circumstances)



SIGNATURE DATE:

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026			Contract Number:	FA-02-14632-15	
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare	
Contractor				Contract Identification Number		
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-		
Service Description						
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population						
Contract Begin Date				Contract End Date		
7/1/2001				12/31/2006		
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	4A2	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$87,748,111.00	\$87,748,111.00			\$175,496,222.00	
2007	\$51,672,172.00	\$51,672,172.00			\$103,344,344.00	
Total:	\$245,094,781.35	\$ 264,930,646.55			\$510,025,427.90	
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.			Check the box ONLY if the answer is YES:		
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)		
Name:	Scott Pierce			Is the Contractor a Vendor? (per OMB A-133)		
Address:	310 Great Circle Road			Is the Fiscal Year Funding STRICTLY LIMITED?		
Phone:	Nashville, TN (615)507-6415			Is the Contractor on STARS?		
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?		
Scott Pierce 				Is the Contractor's Form W-9 Filed with Accounts?		
COMPLETE FOR ALL AMENDMENTS (only)				Funding Certification		
	Base Contract & Prior Amendments	This Amendment ONLY		Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.		
CONTRACT END DATE:	12/31/2006					
FY: 2002	\$ 18,599,868.48					
FY: 2003	\$ 33,079,942.80					
FY: 2004	\$ 63,490,156.62					
FY: 2005	\$116,014,894.00					
FY: 2006	\$175,496,222.00					
FY: 2007	\$58,007,447.00	\$45,336,897.00				
Total:	\$464,688,530.90	\$45,336,897.00				

AMENDMENT NUMBER 15

**AN AGREEMENT FOR THE ADMINISTRATION OF TENNCARE SELECT
BETWEEN
THE STATE OF TENNESSEE,
d.b.a. TENNCARE
AND
VOLUNTEER STATE HEALTH PLAN, INC.**

CONTRACT NUMBER: FA-02-14632-00

For and in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to clarify and/or amend the Amended and Restated Contractor Risk Agreement (CRA) by and between the State of Tennessee TennCare Bureau, hereinafter referred to as TENNCARE, and VOLUNTEER STATE HEALTH PLAN, INC., hereinafter referred to as the CONTRACTOR as specified below.

Titles and numbering of paragraphs used herein are for the purpose of facilitating use of reference only and shall not be construed to infer a contractual construction of language.

1. For clarification purposes to describe current TENNCARE policy, Section 1-3 shall be amended by adding the phrase "with the exception of Medical Case Management" and correcting references to the definition of Administrative Cost and adding a new definition of Medical Expenses which shall read as follows:

Administrative Cost - All costs to the Contractor related to the administration of this Agreement that are non-medical in nature, including, but not limited to:

- Satisfying Contractor Qualifications specified in Sections 2-1 and 2-2;
- Establishing and Maintaining a Provider Network in accordance with the Access and Availability requirements specified in Section 2-4.1, Attachment III and Attachment IV;
- Determination of recoveries from Third Party Liability resources in accordance with Section 2-9.8;
- Claims Processing in accordance with Section 2-9.7;
- Administration of this Agreement in accordance with Medical Management Policies and Procedures including: Utilization Management policies and procedures, including prior authorization policies and procedures established in accordance with Section 2-7.1; Referral and Exemption Requirements established in accordance with Section 2-4.4; Out of Area or Out of Plan Use policies and procedures established in accordance with Section 2-4.7; Transplant policies and procedures established in accordance with Section 2-3.13; Prescription Drug Formulary established in accordance with Section 2-3.14; Prenatal Care policies and procedures established in accordance with Section 2-7.1.f.3 and 2-3.16; Quality Monitoring/Quality Improvement Program established in accordance with Section 2-9.6; Management of Medical Care and Coordination of Care policies and procedures established in accordance with Sections 2-4.2 and 2-4.3 with the exception of Medical Case Management;
- Enrollment and Disenrollment in accordance with Section 4;
- Appeals processing and resolution in accordance with Section 2-8;
- Quality Assurance and Improvement activities as specified in Section 2-9.6 and Attachment II;
- Production and submission of required reports as specified in Section 2-10;
- Production and distribution of Marketing and Enrollee Materials as specified in Section 2-6;
- All other Administration and Management responsibilities as specified in Sections 2-11 through 2-24 and other activities required to be conducted in Attachment I, V, VI, VII, XI, XII, XIII; and

- All costs related to third party recovery or subrogation activities whether performed by the Contractor or a subcontractor.

Costs of subcontractors engaged solely to perform a non-medical administrative function for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to TENNCARE under the terms of this Agreement (e.g., claims processing, marketing) are considered to be an "administrative cost" with the exception of the cost of recovery of third party liability (TPL), when approved by TENNCARE.

Medical Expenses (sometimes referred to as "Covered Services") - Consist of the following:

- a. The cost of providing TennCare Program medical services to enrollees as identified below and pursuant to the following listed subsections of Section 2-3 of the CRA:
 1. 2-3.1 Covered Benefits
 2. Coordination, 2-3.5 and 6 Dental Services/Mental Health and Substance Abuse Services
 3. 2-3.10 Use of Cost Effective Alternative Services
 4. 2-3.11 Coverage of Sterilization's, Abortions and Hysterectomies pursuant to applicable federal and state laws and regulations
 5. 2-3.13 Coverage of Organ and Tissue Transplants
 6. all services related to hospice
 7. capitated payment to licensed health care providers
 8. medical services directed by TENNCARE or an Administrative Law Judge
 9. net impact of reinsurance coverage purchased by the MCO
- b. Preventive Services: In order for preventive services in Section 2-3 (including, but not limited to, health education, medical case management and health promotion activities) to qualify as medical expenses, the service must be targeted to and limited to the CONTRACTOR's enrollees or targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs must be approved by TENNCARE.
- c. Medical case management may qualify as medical expenses if the service is targeted to meet the enrollee's individual needs and the allocation methodology for capturing said costs is approved by TENNCARE.
- d. Medical Expenses do not include:
 1. 2-5. Services Not Covered;
 2. 2-3.8. Institutional Services and Alternatives to Institutional Services;
 3. Services eligible for reimbursement by Medicare;
 4. The activities described in or required to be conducted in Attachments I, II, III, IV, V, VI, VII, XI, XII, XIII (including, but not limited to, utilization management, utilization review activities) are administrative costs; and
 5. The two percent HMO tax.
- e. Medical expense will be net of any TPL recoveries or subrogation activities. If approved by TENNCARE, the TPL or subrogation recoveries may be net of administrative expenses incurred that are related to recovery activities.
- f. Medical expense will be net of any pharmacy rebates.

f. This definition does not apply to NAIC filings.

2. Section 1-3 shall be amended by deleting and replacing the definition of "Medically Necessary" so that the amended definition shall read as follows:

Medically Necessary – Shall be defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary," as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term "medically necessary" is provided for in regulations at 1200-13-16-.01, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in regulations at 1200-13-16-.01.

3. Section 2-3.1.2 shall be deleted and replaced in its entirety so that the amended Section 2-3.1.2 shall read as follows:

2-3.1.2 TennCare Benefits, effective July 1, 2006:

Should TENNCARE eliminate a specified population from eligibility in the TennCare Program, Services/Benefits listed below shall no longer be applicable for said population.

SERVICE	BENEFIT
Inpatient Hospital Services	<p>Medicaid/Standard Eligible, Age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services are Not covered for adults. May be provided by the CONTRACTOR if determined by the CONTRACTOR to be a cost effective alternative.</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary, rehabilitation hospital facility services are covered under EPSDT for Medicaid eligible children and as medically necessary for Standard eligible children.</p>
Outpatient Hospital Services	As medically necessary.
Physician Inpatient Services	As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	<p>As medically necessary.</p> <p>NOTE: CONTRACTOR covered services shall include the following:</p> <ul style="list-style-type: none"> • Services provided by a Primary Care Provider with a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx). • Behavioral health services described in CPT procedure code range 96150 through 96155. • Medical evaluations provided by a neurologist, as approved by the CONTRACTOR, and/or an emergency room provider, that result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).

	result in a primary behavioral health diagnosis (ICD-9-CM 290.xx - 319.xx).
EPSDT Services for enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.	<p>Medicaid/Standard Eligibles, Age 21 and older: not covered.</p> <p>Medicaid/Standard Eligibles, Under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. Except for Dental services, Screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care". Dental screens shall be in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Tools to be used for screenings shall be consistent with the EPSDT Screening Guidelines as described in Attachment VIII of the Contract. EPSDT services also include maintenance services which are services which have been determined to be effective in preventing or mitigating the worsening of an individual's conditions or preventing the development of additional health problems.</p>
Preventive Care Services	As described in Section 2-3.3.
Lab and X-ray Services	As medically necessary.
Hospice Care	<p>As medically necessary. Must be provided by a Medicare-certified hospice.</p> <p>If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR must pay an amount equal to at least 95 percent of the prevailing NF room and board rate to the hospice provider.</p>
Dental Services	<p>Dental Services shall be provided by the Dental Benefits Manager.</p> <p>Medicaid/Standard Eligible, Age 21 and older: Non-covered.</p> <p>Medicaid/Standard Eligible, Under age 21: The CONTRACTOR shall cover Dental preventive, diagnostic and treatment services for enrollees under age 21. Orthodontics limited to individuals under 21</p>

	<p>except when an orthodontic treatment plan is approved prior to the enrollee attaining 20 1/2 years of age, and treatment is initiated prior to the recipient attaining 21 years of age.</p> <p>Effective October 1, 2002, the aforementioned covered dental services shall be provided by the Dental Benefits Manager. The provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall remain with the CONTRACTOR when the dental service is covered by the DBM.</p> <p>(See Section 2-3.1, and 2-3.5)</p>
Vision Services	<p>Medicaid/Standard Eligible, Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered but shall be subject to the service limitations as described elsewhere in this Contract. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses will not be covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.</p> <p>Medicaid/Standard Eligible, Under age 21: Preventive, diagnostic, and treatments services (including eyeglasses), are covered as medically necessary.</p>
Home Health Care	As medically necessary.
Pharmacy Services	<p>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</p> <p>Non-Institutionalized Mandatory and Optional (other than Medically Needy) Medicaid Adults (Age 21 and older) and Medically Needy Adults (Age 21 and older): 5 Prescriptions per Month of which only 2 may be Brand name</p> <p>Institutionalized Medicaid Adults (Age 21 and older): As medically necessary</p> <p>Standard Eligible, Age 21 and older: Non-covered</p> <p>Medicaid/Standard Eligible, Under age 21: As medically necessary</p> <p>NOTE: Certain drugs (known as DESI, LTE, or IRS drugs) are excluded from coverage.</p> <p>Limits on Pharmacy benefits as well as the effective dates thereof are</p>

	<p>subject to change based on Waiver and/or Court negotiations.</p> <p>Effective July 1, 2003, the aforementioned covered pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM) contracted by the TENNCARE Bureau. Pharmacies providing home infusion drugs and biologics <u>only (not including services)</u> shall bill the PBM.</p> <p>Diabetic monitors and supplies as well as injectable drugs obtained directly from a pharmacy provider shall be included in the covered pharmacy services that will be provided by the TennCare Pharmacy Benefit Manager effective July 1, 2003.</p> <p>CONTRACTOR RESPONSIBILITIES: The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting in accordance with benefits described herein and to providers providing both home infusion services and the drugs and biologics. Effective July 1, 2005, the CONTRACTOR shall require that all home infusion claims contain NDC coding and unit information to be paid.</p> <p>Services reimbursed by the CONTRACTOR shall not be included in the Pharmacy Benefit Limits as described above.</p> <p>Effective January 1, 2006, provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible shall be administered by Medicare Part D.</p>
Durable Medical Equipment	<p>As medically necessary.</p> <p>Specified DME services shall be covered/non-covered in accordance with the TennCare rules and regulations.</p>
Medical Supplies	<p>As medically necessary.</p> <p>Specified Medical Supplies shall be covered/non-covered in accordance with the TennCare rules and regulations.</p>
Emergency Air And Ground Ambulance Transportation	<p>As medically necessary.</p>
Non-emergency Transportation (including Non-Emergency Ambulance Transportation)	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee,</p>

	<p>transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollees age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollees age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>The CONTRACTOR shall provide transportation to and from Dental Services.</p>
Renal Dialysis Services	As medically necessary.
Private Duty Nursing	As medically necessary and when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative.
Speech Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Occupational Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Occupational Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Physical Therapy	<p>Medicaid/Standard Eligible, Age 21 and older: Covered as medically necessary when provided by a Licensed Physical Therapist to restore, improve, or stabilize impaired functions.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Organ and Tissue Transplant And Donor Organ Procurement	<p>Medicaid/Standard Eligible, Age 21 and older: All medically necessary and non-investigational/experimental organ and tissue transplants, as covered by Medicare, are covered. These include, but may not be limited to:</p> <p>Bone marrow/Stem cell;</p>

	<p>Cornea; Heart; Heart/Lung; Kidney; Kidney/Pancreas; Liver; Lung; Pancreas; and Small bowel/Multi-visceral.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements. Experimental or investigational transplants are not covered.</p>
Reconstructive Breast Surgery	<p>Covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.</p>
Chiropractic Services	<p>Medicaid/Standard Eligible, Age 21 and older: Not covered. May be provided by the CONTRACTOR if determined by the CONTRACTOR to be a cost effective alternative.</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary in accordance with EPSDT requirements.</p>
Sitter	<p>Medicaid/Standard Eligible, Age 21 and older: NON COVERED</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>
Convalescent Care	<p>Medicaid/Standard Eligible, Age 21 and older: NON COVERED</p> <p>Medicaid/Standard Eligible, Under age 21: Covered as medically necessary.</p>

4. Section 2-3 shall be amended by adding a new Section 2-3.2 and renumbering the existing Sections accordingly and shall update all references thereto. The new Section 2-3.2 shall read as follows:

2-3.2. Soft Limits/Service Thresholds for Certain Physical Health Services

TENNCARE has established thresholds that apply to certain covered physical health services for non-institutionalized Medicaid adults. The CONTRACTOR shall track, in a manner prescribed by TENNCARE, and report on accumulated benefit information for each service that has a threshold. Depending on the service, once a member reaches a threshold, the CONTRACTOR shall evaluate and enroll the member in MCO case management or a disease management program as appropriate.

"Institutionalized Medicaid" are not subject to service thresholds and shall be defined as individuals who are receiving (as described in TennCare/Medicaid rules and regulations) long term care institutional services in a nursing home, an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or waiver covered services provided through the Home and Community Based Services (HCBS) waiver for these institutional services.

- 2-3.2(a) The service thresholds and the CONTRACTOR's responsibility once a non-institutionalized adult has met the threshold are as follows:

Service	Threshold for Non-Institutionalized Medicaid Eligibles, Age 21 and Older	CONTRACTOR Responsibility Once Member Has Reached Threshold
Inpatient Hospital Services	20 days per SFY	Enroll member in MCO case management or disease management program, whichever is more appropriate
Outpatient Hospital Services	8 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	12 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate
Lab and X-ray Services	10 visits per SFY	Determine whether member should be enrolled in MCO case management or a disease management program and enroll member if appropriate

- 2-3.2(b) The CONTRACTOR shall report, on a quarterly basis as described in Section 2-10.18, the number of members who reach each threshold, were assessed, and/or were enrolled in MCO case management or a disease management program, and the reasons for failure to enroll in MCO case management or disease management.

5. The second paragraph of the renumbered Section 2-3.17 shall be amended by adding a new third sentence so that the first two paragraphs of Section 2-3.17 shall read as follows:

2-3.17. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements

The CONTRACTOR must have written policies and procedures for an EPSDT program that includes coordinating services with other TennCare providers, providing all medically necessary Title XIX EPSDT services to all eligible individuals under the age of twenty-one (21) regardless of whether the service is included in the Medicaid State Plan, as well as outreach and education. The CONTRACTOR must assure the availability and accessibility of required health care resources and help enrollees and their parents or guardians use these resources effectively. The

State EPSDT program shall be referred to as "TENnderCare". The CONTRACTOR shall use "TENnderCare" in describing or naming an EPSDT program or services. This shall include, but not be limited to, all policies, procedures and/or marketing material, regardless of the format or media. No other names or labels shall be utilized. CONTRACTORS may, however, use existing EPSDT materials through December 31, 2004. Any new or reprinted EPSDT materials shall use TENnderCare as of July 1, 2004.

The CONTRACTOR shall provide EPSDT services to enrollees under age 21 in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. EPSDT Services means early and periodic screening, diagnosis and treatment of enrollees under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B to ascertain children's individual (or individualized/or on an individual basis) physical and mental defects, and providing treatment to correct or ameliorate, or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan. The CONTRACTOR shall be responsible for and comply with all provisions related to screening, vision, dental, and hearing services (including making arrangements for necessary follow-up if all components of a screen cannot be completed in a single visit). The CONTRACTOR shall be responsible for the provision of all related services except for behavioral health services that are carved out as a separate arrangement from this Contract as well as Pharmacy and Dental services at such time as they are removed from the responsibilities described in this Contract. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

6. The renumbered Section 2-3.17.2 shall be amended by deleting and replacing the last paragraph so that the amended Section 2-3.17.2 shall read as follows:

2-3.17.2 42 CFR 441.56(b) defines "screening" as "periodic comprehensive child health assessments" meaning "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth." At a minimum, screenings must include, but are not limited to:

1. Comprehensive health and developmental history;
2. Comprehensive unclothed physical examination;
3. Appropriate Immunizations;
4. Appropriate vision and hearing testing;
5. Appropriate laboratory tests; and
6. Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate; and
7. Health Education.

At a minimum, these screening services shall include periodic and interperiodic screens and must be provided in accordance with "reasonable standards of medical and dental practice" as determined by the State. The State has determined that "reasonable standards of medical and dental practice" are those standards set forth in the American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Pursuant to Section 2-3.4, "screens shall be in accordance with the periodicity schedule set forth in the latest 'American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care' and all components of the screens must be consistent with the latest 'American Academy of Pediatrics

Recommendations For Preventive Pediatric Health Care” and the American Academy of Pediatric Dentistry (AAPD) guidelines. The CONTRACTOR shall not require prior authorization for periodic and interperiodic screens conducted by PCPs. The CONTRACTOR shall provide all medically necessary TENNCare covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the CONTRACTOR or by an in-network provider.

7. Section 2-4.6 shall be amended by adding new language to the end of the existing text so that the amended Section 2-4.6 shall read as follows:

2-4.6 Network Notice Requirements

All member notices required shall be written using the appropriate notice templates provided by TENNCARE and shall include all notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective. The CONTRACTOR shall provide notice of changes to its provider network as specified below.

Failure to comply with notice requirements described herein may result in liquidated damages as described in Section 6-8.b.2 of this Agreement.

8. Section 2-4.6.2.c shall be amended by deleting and replacing the first sentence of the first paragraph so that the amended Section 2-4.6.2.c shall read as follows:

c. Other Provider Terminations

Other Provider Terminations. The CONTRACTOR shall notify TennCare of any provider termination and submit a copy of one of the actual member notices mailed as well as an electronic listing identifying each member to whom a notice was sent within five (5) business days of the date the member notice was sent as required in Section 2-4.6.1. In addition to the member notice and electronic listing, documentation from the CONTRACTOR's mail room or outside vendor indicating the quantity and date member notices were mailed shall be sent to TENNCARE as proof of compliance with the member notification requirements. The CONTRACTOR shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TENNCARE. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

Furthermore, if termination of the CONTRACTOR's provider agreement with any primary care provider or physician group or clinic, whether or not the termination is initiated by the provider or by the CONTRACTOR, places the CONTRACTOR out of compliance with Section 2-4, such termination shall be reported by the CONTRACTOR in writing to the Bureau of TennCare, in the standard format used to demonstrate compliance with provider network and access requirements, within five (5) business days of the date that the agreement has been terminated.

9. The second paragraph of Section 2-4.7.1 shall be amended by deleting the phrase “and subsequent steps regarding an informal review by TENNCARE” so that the amended Section 2-4.7.1 shall read as follows:

2.4.7.1 Emergency Medical Services obtained from Out of Plan Providers

The CONTRACTOR's plan shall include provisions governing utilization of and payment by the CONTRACTOR for emergency medical services received by an enrollee from non-contract providers, regardless of whether such emergency services are rendered within or outside the

community service area covered by the plan. Coverage of emergency medical services shall not be subject to prior authorization by the CONTRACTOR and shall be consistent with federal requirements regarding post-stabilization services, including but not limited to, 42 CFR Section 438.114(c)(1)(ii)(A). Utilization of and payments to non-contract providers may, at the CONTRACTOR's option, be limited to the treatment of emergency medical conditions, including post-stabilization care that includes medically necessary services rendered to the enrollee until such time as he/she can be safely transported to an appropriate contract service location. Payment amounts shall be consistent with the pricing policies developed by the CONTRACTOR and in accordance with TENNCARE requirements, including TENNCARE rules and regulations for emergency out-of-plan services. Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within thirty (30) calendar days of receipt of a clean claim by the CONTRACTOR.

The CONTRACTOR must review and approve or disapprove claims for emergency medical services based on the definition of emergency medical services specified in Section 1-3 of this Contract. If the CONTRACTOR determines that a claim requesting payment of emergency medical services does not meet the definition as specified in Section 1-3 and subsequently denies the claim, the CONTRACTOR shall notify the provider of the denial. This notification shall include information to the provider regarding the CONTRACTOR's process and timeframes for reconsideration. In the event a provider disagrees with the CONTRACTOR's decision to disapprove a claim for emergency medical services, the provider may pursue the independent review process for disputed claims as provided by T.C.A., Section 56-32-226, including but not limited to MCO reconsideration.

10. Section 2-4.7.6 shall be amended by adding a new paragraph to the end of the existing text so that the amended Section 2-4.7.6 shall read as follows:

2-4.7.6. Credentialing of Non-Contract Providers

Credentialing Standards must apply to all licensed independent practitioners or groups of practitioners who have an independent relationship with the CONTRACTOR. An independent relationship is not synonymous with an independent contract.

The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTOR's network.

11. Section 2-6.2.c.1 shall be amended by deleting and replacing Item (t) so that the amended Section 2-6.2.c.1(t) shall read as follows:

- (t) Shall include member services toll free telephone numbers; including the TENNCARE Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line with a statement that the enrollee may contact the plan or TENNCARE regarding questions about TennCare as well as the service/information that may be obtained from each line. The TennCare hotline number is 1-866-311-4287;

12. Section 2-6.2.c.2 shall be amended by adding a new Item (e) and renumbering the existing item (e) as (f) so that the new Section 2-6.c.2.c.2(e) shall read as follows:

- (e) member services toll free telephone numbers; including the TennCare Hotline, the CONTRACTOR's customer service line and the CONTRACTOR's 24/7 Nurse Triage Line as well as the service/information that may be obtained from each line; and
13. Section 2-6.2.c.4 shall be amended by adding the phrase "or prior to enrollee's beginning effective date" to the end of the first sentence so that the amended Section 2-6.2.c.4 shall read as follows:

4. Provider Directory

The CONTRACTOR shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan or prior to enrollee's beginning effective date. The CONTRACTOR shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. Provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network PCPs and specialists, hospital listings including locations of emergency settings and post stabilization services, identification of providers accepting new patients and whether or not a provider performs EPSDT screens. Enrollee provider directories, and any revisions thereto, shall be submitted to TENNCARE for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TENNCARE and be produced using the same extract process as the actual enrollee provider directory. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the CONTRACTOR to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case. These updates shall be maintained in accordance with Section 2-1.o of this Contract.

14. Section 2-7.1.b shall be deleted and replaced in its entirety so that the amended Section 2-7.1.b shall read as follows:

b. MCO Case Management

- (1) The CONTRACTOR shall maintain an MCO case management program that includes the following components:
 - (a) A systematic approach to identify eligible members;
 - (b) Assessment of member needs;
 - (c) Development of an individualized plan of care;
 - (d) Implementation of the plan of care, including coordination of care that actively links the member to providers and support services; and
 - (e) Monitoring of outcomes.
- (2) The CONTRACTOR shall provide MCO case management to members who are at high risk or have unique, chronic, or complex needs. This shall include but not be limited to:

- (a) Members who have reached the service threshold for inpatient hospital services;
 - (b) Members who have reached the service threshold for non-inpatient hospital services and could potentially benefit from enrollment in MCO case management;
 - (c) Members with co-occurring mental illness and substance abuse, and/or co-morbid physical health and behavioral health conditions;
 - (d) Members who meet the requirements at 2-7.1.b(1) regarding excessive and/or inappropriate Emergency Department Utilization, and
 - (e) Children with special health care needs unless already enrolled in an appropriate disease management program.
- (3) Members who have reached the service threshold for inpatient hospital services shall be enrolled in either MCO case management or a disease management program.
- (4) Eligible members must be offered MCO case management services. However, member participation shall be voluntary.
- (5) The CONTRACTOR shall develop a process to inform members and providers about the availability of MCO case management and to inform the member's PCP when a member has been assigned to the MCO case management program.
- (6) The CONTRACTOR shall use utilization data, including pharmacy data provided by TENNCARE or its PBM to identify members for MCO case management services as appropriate. In particular, the CONTRACTOR shall track utilization data to determine when a member has reached a service threshold.
15. Section 2-7.1.e shall be amended by adding additional text to the end of the existing text so that the amended Section 2-7.1.e shall read as follows:

e. Excessive and/or Inappropriate Emergency Department (ED) Utilization. The CONTRACTOR shall utilize the following guidelines in identifying and managing care for enrollees who are determined to have excessive and/or inappropriate ED utilization.

- (1) Review ED utilization data, at a minimum, every six (6) months (in January and July) to identify enrollees with utilization exceeding a threshold defined by TENNCARE in the preceding six (6) month period. In January, review ED utilization during the preceding April through September. In July review ED utilization during the preceding October through March.
- (2) Enroll in active case management – (Enrollees who exceed a specified number, to be defined by TENNCARE, of ED visits in the previous six (6) month period)
- (3) Make contact with enrollee and primary care provider
- (4) Review encounter data
- (5) Assess most likely cause of problem (e.g., drug seeking behavior, primary care/access problem, poorly controlled disease state, etc.)
- (6) Develop a case management plan based on results of the assessment. Sample plans based on potential assessment results follow:
 - (a) Drug seeking behavior
 - i. Interact with TennCare Pharmacy Division regarding possibility of pharmacy lock-in and/or controlled substance prior authorization requirement

- ii. Contact all providers regarding concern that patient may be abusing prescription medications
 - iii. Make appropriate referrals (e.g., OIG, Pain clinic, Substance abuse treatment program, etc.)
 - iv. Consider primary care provider lock-in (i.e. patient must have PCP approval before he/she can access other providers)
- (b) Primary Care /Access Problem
 - i. Change PCP and/or address problem with current PCP
 - ii. Provide enrollee education regarding appropriate use of PCP and ED
 - iii. Provide access to a 1-800 customer service line for assistance identifying and selecting a PCP and to the extent necessary assistance scheduling an appointment with PCP
- (c) Poorly controlled disease
 - i. Enroll in disease management
 - ii. Refer to specialist for management – advise PCP
 - iii. Provide access to 1-800 24/7 nurse answered line capable of providing health information/education to patients; healthcare counseling/telephone triage to assess health status to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure effective patient management by avoiding over-utilization in inappropriate settings.
- (7) Any blanket policy to deny payment for specified "non-emergency" services in the ED based on diagnoses must be accompanied by the following guidelines.
 - (a) Clear communication to all hospitals/EDs regarding the diagnoses that are and are not considered emergencies;
 - (b) A process whereby the hospital could demonstrate that a condition on the list did, in fact, represent an emergency;
 - (c) Clear communication to all hospitals/EDs regarding the mechanism to bill for the EMTALA required screen associated with any non-emergency diagnoses;
 - (d) Payment for the EMTALA screens associated with any non-emergency diagnosis, and
 - (e) A specific process that the MCO shares with all hospitals/EDs by which the ED can contact the MCO 24/7 to refer an enrollee with one of the non-emergency diagnoses to the MCO for assistance in arranging for care in an alternative setting, when such assistance is requested by the member.
- (8) If the CONTRACTOR requires EDs to refer members with non-urgent/emergent conditions to alternative settings for treatment, the MCO must have a specific process in place whereby the ED can contact the MCO 24/7 to assist enrollees with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting.

If the CONTRACTOR chooses to implement a blanket policy as identified in subsection (g) above, failure to comply with the ED guidelines as described therein may result in liquidated damages as described in Section 4-8.b.2 of this Agreement.

16. Section 2-7.1.f shall be deleted in its entirety and replaced by a new Section 2-7.1.f which shall read as follows:

- f. Disease Management. Each MCO is required to establish and operate (either directly or via a subcontract with a disease management vendor) a minimum of four disease management (DM) programs designed to address maternity care management, comprehensive diabetes management, management of congestive heart failure and management of asthma.

Each DM program must utilize evidence-based best practice guidelines and patient empowerment strategies to support the practitioner-patient relationship and the plan of care. The programs must emphasize prevention of exacerbation and complications as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

(1) DM Program Policies and Procedures

The CONTRACTOR shall develop and maintain DM program policies and procedures. These policies and procedures must include, for each of the conditions listed above, the following:

- (a) Definition of the target population;
- (b) Member identification strategies;
- (c) Program content including, but not limited to:
 - (a) Evidence-based best practice guidelines upon which the program is based;
 - (b) Written description of the stratification levels for each of the conditions, including member criteria and associated interventions;
 - (c) Methods for informing and educating members;
 - (d) Methods for informing and educating providers; and
- (d) Program evaluation.

As part of its DM program policies and procedures, the CONTRACTOR shall also address how the DM programs will coordinate with MCO case management activities, in particular for members who would benefit from both.

(2) Member Identification Strategies

The MCO must have a systematic method of identifying and enrolling eligible members in each DM program. This shall include but not be limited to:

- (a) Members who have reached the service threshold for inpatient hospital services (see Section 2-3.2).
- (b) Members who have reached the service threshold for other non-inpatient hospital services (see Section 2-3.2) and could potentially benefit from enrollment in a disease management program.
- (c) Members who meet the requirements at 2-7.1.e(6)(c) regarding excessive and/or inappropriate Emergency Department Utilization who could potentially benefit from enrollment in a disease management program.
- (d) Members who have reached the service threshold for inpatient hospital services shall be enrolled in either a disease management program or MCO case management, whichever the CONTRACTOR determines is more appropriate.

The MCO must operate each program using an "opt out" methodology, meaning that services will be provided to eligible members unless they specifically ask to be excluded. The Bureau may elect to mandate the eligibility criteria the MCO must use if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the criteria in use are overly restrictive.

(3) Program Content

The MCO must adopt clinical practice guidelines that serve as the basis for each DM program. The guidelines must be evidence-based and formally adopted by the QI or other clinical committee. The guidelines must be distributed to practitioners who are likely to use them and must be made available to the Bureau upon request. Upon enrollment in the DM program, the MCO must provide information to the member and practitioner regarding how to use the services and specific information to the practitioner concerning how the program works with the practitioner's patients. MCOs must provide primary care providers with a list of their patients enrolled in each program upon initial enrollment and at least annually thereafter.

Each DM program must be based on a treatment plan that serves as the outline for all of the activities/interventions in the program. At a minimum the activities/interventions associated with the treatment plan must address condition monitoring, patient adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues. The Bureau may elect to mandate an intervention strategy the MCO must employ if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the interventions are suboptimal.

(4) Stratification

As part of the DM programs, the CONTRACTOR shall classify eligible members into stratification levels according to condition severity or other clinical or member-provided information. The DM programs shall tailor the program content, education activities, and benchmarks and goals for each risk level.

(5) CONTRACTOR's Program Description

Annually, on July 1, the CONTRACTOR shall submit a description of its Disease Management Program that shall include the following:

1. Definition of the target population for each program and the method used to identify and enroll members; and
2. Written description of the stratification levels for each of the four (4) programs, including member criteria and associated interventions.

(6) Informing and Educating Members

The DM programs shall educate members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:

- (a) Are proactive and effective partners in their care;
- (b) Understand the appropriate use of resources needed for their care;
- (c) Identify precipitating factors and appropriate responses before they require more acute intervention; and
- (d) Are compliant and cooperative with the recommended treatment plan.

(7) Informing and Educating Providers

As part of the DM programs, the CONTRACTOR shall educate providers regarding the guidelines and shall distribute the guidelines to providers who are likely to treat enrollees with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The CONTRACTOR shall also provide each PCP with a list of their patients enrolled in each DM program upon the member's initial enrollment and at least annually thereafter. The CONTRACTOR shall provide specific information to the provider concerning how the program(s) works. The DM's provider education shall be designed to increase the providers' adherence to the guidelines in order to improve the members' conditions.

(8) Program Evaluation

The CONTRACTOR shall establish measurable benchmarks and goals for each DM program and shall evaluate the programs using these benchmarks and goals. These benchmarks and goals shall be specific to each condition but should include the following information. This information shall be reported to TENNCARE annually on July 1st in accordance with Section 2-10.13.7.

- (a) The total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required DM programs;
- (b) The active participation rate (as defined by NCQA) for each of the required DM programs, including the numerator and denominator used in calculating the rate
- (c) The number of individuals participating in each level or stratification of each of the DM programs;
- (d) Performance measured against at least two important aspects of the clinical practice guidelines associated with each DM program;
- (e) The rate of emergency department utilization and inpatient hospitalization for members with diabetes, asthma and congestive heart failure (rate calculations must be shown);
- (f) Neonatal Intensive Care Unit (NICU) days for births associated with members enrolled in the Maternity Management Program;
- (g) HEDIS measures related to any of the four DM projects; and
- (h) Any other performance measure associated with any of the four DM programs that the MCO has chosen to track.

17. Section 2-8 shall be deleted and replaced in its entirety so that the new Section 2-8 shall read as follows:

2-8. Complaints and Appeals

Members shall have the right to file appeals regarding adverse actions taken by the CONTRACTOR. For purposes of this requirement, appeal shall mean a member's right to contest verbally or in writing, any adverse action taken by the CONTRACTOR to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the CONTRACTOR which impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including but not limited to, a provider with the member's written consent. Complaint shall mean a member's right to contest any other action taken by the CONTRACTOR or service provider other than those that meet the definition of an adverse action. The CONTRACTOR shall inform members of their complaint and appeal rights in the member handbook in compliance with the requirements in Section 2-6.2.c.1. The CONTRACTOR shall have internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees, or court orders governing the appeals process.

The CONTRACTOR shall devote a portion of its regularly scheduled QM/QI committee meetings, as described in Section 2-9.8., to the review of member complaints and appeals that have been received.

The CONTRACTOR shall ensure that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

2-8.a. Appeals

The CONTRACTOR's appeal process shall include, at a minimum, the following:

2-8.a.1. The CONTRACTOR shall have a contact person who is knowledgeable of appeal procedures and direct all appeals, whether the appeal is verbal or the member chooses to file in writing, to TENNCARE. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail or fax to the designated TENNCARE P. O. Box or fax number for medical appeals.

2-8.a.2. The CONTRACTOR shall have sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of adverse actions affecting a TennCare member. The CONTRACTOR shall notify TENNCARE of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing appeal procedures, as they become effective.

2-8.a.3. The CONTRACTOR shall educate its staff concerning the importance of the appeals procedure, the rights of the member, and the time frames in which action must be taken by the CONTRACTOR regarding the handling and disposition of an appeal.

2-8.a.4. The CONTRACTOR shall identify the appropriate individual or body within the plan having decision-making authority as part of the appeal procedure.

2-8.a.5. The CONTRACTOR shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Appeal forms shall be available at each service site and by contacting the CONTRACTOR. However, members shall not be required to use a TENNCARE approved appeal form in order to file an appeal.

2-8.a.6. Upon request, the CONTRACTOR shall provide members a TENNCARE approved appeal form(s).

2-8.a.7. The CONTRACTOR shall provide reasonable assistance to all appellants during the appeal process.

2-8.a.8. At any point in the appeal process, TENNCARE shall have the authority to remove a member from the CONTRACTOR's MCO when it is determined that such removal is in the best interest of the Member and TENNCARE.

2-8.a.9. The Contractor shall require providers to display notices of member's right to appeal adverse actions affecting services in public areas of each facility in accordance with TennCare rules and regulations. The Contractor shall ensure that providers have correct and adequate supply of public notices.

- 2-8.a.10 Neither the CONTRACTOR nor TENNCARE shall prohibit or discourage any individual from testifying on behalf of a member.
- 2-8.a.11. The CONTRACTOR shall ensure compliance with all notice requirements and notice content requirements specified in applicable state and federal law, TennCare rules and regulations, and all court orders and consent decrees governing notice and appeal procedures, as they become effective.
- 2-8.a.12. TENNCARE may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which shall be followed by the CONTRACTOR. However, the CONTRACTOR shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, the CONTRACTOR shall not be required to comply with such guidelines or rules during any period of such inapplicability.
- 2-8.a.13 The CONTRACTOR shall provide general and targeted education to providers regarding expedited appeals(described in TennCare rules and regulations), including when an expedited appeal is appropriate, and procedures for providing written certification thereof.
- 2-8.a.14. The CONTRACTOR shall require providers to provide written certification regarding whether a member's appeal is an emergency upon request by a member prior to filing such appeal, or upon reconsideration of such appeal by the CONTRACTOR when requested by TENNCARE.
- 2-8.a.15. The CONTRACTOR shall provide notice to contract providers regarding provider responsibility in the appeal process, including but not limited to, the provision of medical records and/or documentation as described in Section 2-9.7.
- 2-8.a.16. The CONTRACTOR shall urge providers who feel they cannot order a drug on the TennCare Preferred Drug List (PDL) to seek prior authorization in advance, as well as to take the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)
- 2-8.a.17. Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and co-payment responsibilities shall be directed to the Department of Human Services.

If it is determined by TENNCARE that violations regarding the appeal guidelines have occurred by the CONTRACTOR, TENNCARE shall require that the CONTRACTOR submit and follow through with a corrective action plan. Failure to comply with the appeal guidelines issued by TENNCARE, including an acceptable corrective action plan, shall result in the CONTRACTOR being subject to liquidated damages as described in Section 6-8. of this Contract.

- 18. Section 2-9.3 shall be amended by adding a new 8 and renumbering the existing 2-9.3.8 through 2.9.3.13 accordingly, including all references thereto, so that the new Section 2-9.3.8 shall read as follows:
 - 8. The CONTRACTOR shall maintain a 1-800 Nurse Triage line that shall be available to members 24 hours a day, seven days a week. The 24/7 Nurse Triage line service shall provide health information/education to patients; healthcare counseling/telephone triage to assess health status in order to steer patients to the appropriate level of care. The 24/7 Nurse Triage line shall assure

effective patient management by avoiding over-utilization in inappropriate settings. The CONTRACTOR shall include information on the Nurse Triage line, including the telephone number and the services/information available by calling the line, in the member handbook and in quarterly member newsletters.

19. Section 2-9.8.6 shall be amended by adding a new second paragraph so that the amended Section 2-9.8.6 shall read as follows:

6. Credentialing and Recredentialing

The CONTRACTOR utilizes current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action. The CONTRACTOR shall further adhere to the credentialing requirements described in Section 2-4.7.6 of this Contract regarding non-contract providers.

The CONTRACTOR shall completely process credentialing applications within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application. Completely process shall mean that the CONTRACTOR shall review, approve and load approved applicants to their provider files in their claims processing system or deny the application and assure that provider is not included in the CONTRACTOR's network.

20. Section 2-9 shall be amended by adding a new 10 and renumbering the existing 10 through 13 as well as all references thereto, so that the new Section 2-9.10 shall read as follows:

2-9.10. Subrogation (Casualty) Recovery

The CONTRACTOR shall conduct diagnosis and trauma code editing to identify potential subrogation related claims. This editing should identify claims with a diagnosis of 800.00 thru 999.99 (excluding 994.6) or a claim submitted with an accident trauma indicator of 'Y'. TENNCARE approved questionnaires or other type TENNCARE approved forms shall be used to gather data and information pertinent to potential subrogation cases. TENNCARE shall determine a threshold amount for which a subrogation case should be pursued.

21. The renumbered Section 2-9.14.a.4 shall be deleted in its entirety and replaced by a new Section 2-9.14.a.4 which shall read as follows:

4. The CONTRACTOR shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, , the CONTRACTOR shall not take any of the following actions as they specifically relate to TennCare claims:
- i. contact the subject of the investigation about any matters related to the investigation,
 - ii. enter into or attempt to negotiate any settlement or agreement regarding the incident, or
 - iii. accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident. .

22. Section 2-10.2.1 shall be amended by adding new text to the end of the existing text so that the amended Section 2-10.2.1 shall read as follows:

2-10.2.1. Enrollee Information, Weekly Reporting

The CONTRACTOR shall submit weekly reports in an electronic format, unless otherwise specified or approved by TENNCARE in writing, which shall serve as the source of information for a change in the enrollee's TennCare information. Such information shall serve as the source of information for a change in the enrollee's address and/or selection of MCO plan. This report shall include enrollees who move outside the CONTRACTOR's service area as well as enrollees who move to a new address within the CONTRACTOR's service area. The CONTRACTOR agrees to work with the State to devise a methodology to use returned mail to identify enrollees who have moved and whose whereabouts is unknown.

Within ninety (90) days of the time that TENNCARE develops and describes to the CONTRACTOR the new reporting procedures, the CONTRACTOR shall also be required to include in the report, described above, any information which is known by the CONTRACTOR that may affect an enrollee's TennCare eligibility and/or cost sharing responsibilities including changes in income, family size, access to health insurance, third party resources including any known insurance policies and/or legal actions, proof of uninsurability including limited coverage and exclusionary riders to policies, whether or not the enrollee is incarcerated, or resides outside the State of Tennessee. The minimum data elements that will be required for this report can be found in Attachment XII, Exhibit A of this Contract.

The CONTRACTOR shall gather, store and update a minimum of the following health insurance information:

- Recipient SSN
- Type of Coverage (Inpatient, outpatient, pharmacy, dental, vision, etc.)
- Policyholder name
- Policyholder SSN, if available
- Policyholder's relationship to the recipient
- TennCare Carrier Number, Carrier name and address, if available
- Policy number
- Begin and end dates of policy.

Health insurance data provided by the CONTRACTOR that does not include the above required fields will be returned to the CONTRACTOR.

23. Section 2-10.3.1 shall be deleted and replaced in its entirety so that the amended Section 2-10.3.1 shall read as follows:

2-10.3.1 Monthly Provider Enrollment File

The CONTRACTOR shall furnish to TENNCARE at the beginning of the Agreement period an electronic report in the format specified by TENNCARE listing all providers enrolled in the TennCare plan, including but not limited to, physicians, dentists, hospitals, home health agencies, pharmacies, medical vendors, ambulance, etc. This listing shall include regularly enrolled providers, specialty or referral providers and any other provider, which may be enrolled for purposes of payment for services provided out-of-plan. The minimum data elements required for all provider listings required in this Section may be found in Attachment XII, Exhibit C of this Agreement. The CONTRACTOR shall be required to inquire as to the provider's race and/or national origin and shall report to TENNCARE the information, if any, furnished by the provider in response to such an

inquiry. The CONTRACTOR shall be prohibited from requiring the provider to declare race and/or national origin and shall not utilize information regarding race or national origin obtained pursuant to such request as a basis for decisions regarding participation in the CONTRACTOR's provider network or in determination of compensation amounts.

Thereafter, a complete electronic provider replacement file (full file refresh) shall be submitted on a monthly basis by the 5th of each month. This information shall be used to determine CONTRACTOR compliance with network adequacy standards and shall be used in conjunction with encounter data.

Each provider shall be identified by a Tennessee Medicaid I.D. number (i.e., each servicing provider in a group or clinic practice must be identified by a separate provider number). This unique identifier shall appear on all encounter data transmittals.

Within ten (10) working days of a request by TENNCARE, the CONTRACTOR shall provide an unduplicated listing of all contracted providers, in a format designated by TENNCARE.

Failure to report the provider information, as specified above, shall result in the application of liquidated damages as described in Section 6.7.2 of this Agreement.

24. Section 2-10.5.3 shall be deleted in its entirety and replaced by a new Section 2-10.5.3 which shall read as follows:

3. Reporting Provider Payment Issues

- (a) If the CONTRACTOR does not automatically credit TENNCARE for receivables within ninety (90) calendar days, the CONTRACTOR shall determine the extent of the collection effort required based on the table below. This table identifies the minimum collection threshold for cumulative receivable balances. All collection efforts shall be clearly documented.

Receivable Balance	Collection Attempts		Forwarded to Collections
	45 Day	90 Day	
< \$10	None Required		
\$10 - \$49.99	✓		
\$50 - \$99.99	✓	✓	
\$100 - Over	✓	✓	✓
Responsibility:	MCC		TENNCARE

The first notice shall occur by day forty-five (45) and may be in the form of notice in a remittance advice or a demand memo; however, the ninety (90) day notice must be made using a demand memo. Each of these notices shall be sent within five (5) business days of becoming due.

Additional collection attempts by the CONTRACTOR are not necessary if a collection notice is returned because the provider has gone out-of-business or has declared bankruptcy for the period the receivable was established. This circumstance must be reported in the "Uncollectible Accounts Report" as described below.

Failure to send the notices as scheduled may result in liquidated damages as described in Section 6-8 of this Contract.

- (b) If the CONTRACTOR does not automatically credit TENNCARE for aged accounts within sixty (60) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an "Aged Accounts Receivable report". The effective date of this report shall be the last Friday of the previous month. The report shall have an easily identifiable date, contain a total report balance, and provide <30, 30, 60, 90, and >120 calendar day balances. Although only totals are required, the CONTRACTOR may report aging balances at the account level. If the CONTRACTOR is not reporting at the account level, the CONTRACTOR shall have the capability to identify the detail that makes up a total if necessary.
- (c) If the CONTRACTOR does not automatically credit TENNCARE for uncollectible accounts within ninety (90) calendar days, the CONTRACTOR shall submit to TENNCARE, within ten (10) business days following the end of the month, an "Uncollectible Accounts Report", in a format described by TENNCARE, for accounts meeting the following criteria:
 - (1) the account proves to be uncollectible after 120 calendar days, or
 - (2) the provider account owner has gone out-of-business, or
 - (3) the provider account owner has declared bankruptcy.

In addition to the "Uncollectible Accounts Report" report, the CONTRACTOR shall submit scanned copies of returned envelopes or legal documents referencing providers that have gone out-of-business and/or declared bankruptcy.

- (d) The Contractor shall provide TENNCARE a report, in a format described by TENNCARE, detailing all checks remitted to providers, enrollees or vendors on behalf of the State which remain outstanding (which have not been cashed) greater than one hundred eighty (180) calendar days. Reports are due monthly within fifteen (15) business days after the end of the month.

Failure to report outstanding checks to TENNCARE as described above may result in liquidated damages as described in Section 6-8 of this Contract.

25. Section 2-10.10.8 shall be deleted and replaced in its entirety so that the amended Section 2-10.10.8 shall read as follows:

2-10.10.8 Cost and Utilization Reports

- a. The CONTRACTOR shall report Cost and Utilization information for: Groups 1.A and 1.B; Group 2; and for all other Groups by TennCare enrollee eligibility category as described in Attachment XII, Exhibits L.1 through L.5 and as required below. CONTRACTOR shall submit a written explanation for how service data will be mapped to the categories identified in said Exhibits by August 1, 2002. These reports shall be maintained in an Excel spreadsheet format and shall be sent via e-mail to TENNCARE on a quarterly basis, based on incurred date, with a ninety (90) day lag and shall be due to TENNCARE one hundred five (105) calendar days following the quarter for which the CONTRACTOR is reporting.
 - 1. Attachment XII, Exhibits L.1 through L.5 shall be submitted for each quarter on a "Cumulative Year to Date" basis.
 - 2. Attachment XII, Exhibits L.1 through L.5 shall be submitted for each quarter on a "Rolling Twelve (12) Month" basis. Please note that the aggregated payment information of these reports for certain reporting periods should be reasonably

ted to the CONTRACTOR's MSBT reports, and invoices/encounters submitted by the CONTRACTOR for the comparable periods.

- b. In order to support federal reporting requirements, the CONTRACTOR shall provide the Cost and Utilization information specified in Attachment XII, Exhibits L.1 through L.5, separately for individuals who are dually eligible for Medicaid and Medicare in response to an adhoc request from TennCare in accordance with the timeframes specified in Section 6-8.

- 26. Section 2-10.13.3 shall be amended by adding "or prior to enrollee's beginning effective date" before "on a quarterly basis" in the first sentence so that the amended Section 2-10.13.3 shall read as follows:

2-10.13.3. PCP Assignment

The CONTRACTOR shall submit a report to TENNCARE including the total number of enrollees and percentage of total enrollees in each Grand Region that have not been assigned to a primary care provider (PCP) within thirty (30) days of enrollment or prior to enrollee's beginning effective date, on a quarterly basis. This report shall be submitted electronically.

- 27. Section 2-10.13.7 shall be deleted and replaced in its entirety so that the amended Section 2-10.13.7 shall read as follows:

2-10.13.7. Disease Management Reports

- (a) The CONTRACTOR shall submit a quarterly *Disease Management Update Report* that includes, for each disease management program as described in Section 2-7.1.f, a brief narrative description of the program, the total number of members in the program, the total number of members enrolled and disenrolled during the quarter, and a description of the specific provider and member interventions performed during the quarter. The report shall be submitted in a format prescribed by TENNCARE.

- (b) Annually on July 1st, the CONTRACTOR shall submit a *Disease Management Report* that includes, the information specified in 2-7.1.f (5) and (8). The report shall be submitted in a format prescribed by TENNCARE.

- 28. Section 2-10 shall be amended by adding a new Section 2-10.18 which shall read as follows:

2-10.18. Benefits/Service Requirements and Limits Reports

The CONTRACTOR shall submit a quarterly *Service Threshold Report* in the format prescribed by TENNCARE. At minimum, the report shall include: the number of members who reached each service threshold; confirmation that all members who reached the service threshold for mandatory enrollment in MCO case management or a disease management program were enrolled; the number of members who reached the service threshold for evaluation of appropriateness for enrollment in MCO case management or disease management who were evaluated for enrollment; the number of those members evaluated who were enrolled in MCO case management or disease management (by program); and the number of those members who were evaluated but not enrolled in MCO case management or disease management by reason.

- 29. Section 2-18.ee shall be amended by deleting "non-emergency" so that the amended Section 2-18.ee shall read as follows:

- 2-18.ee. Specify that the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve claims denied in whole or in part by the MCO as provided at T.C.A. 56-32-226(b).
- 2-18. ff. Include a conflict of interest clause as stated in subsections (a) and (c) of Section 6-7, Gratuities clause as stated in 6-11 and Lobbying clause as stated in 6-12 of this Contract between the CONTRACTOR and TENNCARE;
30. Section 2-24.i shall be amended by adding a new sentence to the end so that the amended Section 2-24.i shall read as follows:
- 2-24.i. On an annual basis, the CONTRACTOR's Title VI Compliance Plan and Assurance of Non-discrimination. The signature date of the CONTRACTOR's Title VI Compliance Plan is to coordinate with the signature date of the CONTRACTOR's Assurance of Non-discrimination Compliance.
31. Section 2-25 shall be amended by adding a new subsection e which shall read as follows:
- e. Payments to the Meharry Medical Services Foundation and/or the Meharry Dental Clinic under this amendment shall not exceed \$13,000,000 for State fiscal year 2007. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the supplemental payment to Meharry Medical Services Foundation and/or the Meharry Dental Clinic shall not exceed \$13,265,306 for State fiscal year 2007. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2007.
32. Section 2-26 shall be amended by adding a new subsection e which shall read as follows:
- e. Payments to the critical access hospitals under this amendment shall not exceed \$10,000,000 for State fiscal year 2007. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. The total obligation to the CONTRACTOR under this amendment including the payments to the hospitals shall not exceed \$10,204,082 for State fiscal year 2007. At such time that Federal Regulations allow, TENNCARE may discontinue making supplemental pool payments through the CONTRACTOR during State fiscal year 2007.
33. Section 2-27 shall be amended by adding a new subsection b which shall read as follows:
- a. Upon notice by TENNCARE, the Contractor will pay each provider the Quarterly Payment Due presented in the schedule provided by TENNCARE each quarter (period covering July 1, 2006 through June 30, 2007) of the State's fiscal year. The amount of quarterly payments may vary. The actual payment amount for each quarter will be provided by TENNCARE and will be based on the disbursement methodology recommended by TENNCARE's actuaries. Disbursements to providers by the CONTRACTOR, under this amendment, shall not exceed **\$100,000,000**, as presented in the schedule provided by TENNCARE. In addition to any interest earned, TENNCARE agrees to pay the CONTRACTOR a sum sufficient to administer this amendment in accordance with state law. Payments to the CONTRACTOR, under this amendment, will not exceed **\$102,040,816**.

34. Section 2-28.b and c shall be deleted and replaced in their entirety so that the amended Section 2-28 shall read as follows:

Community Health Record

- a. Contractor Responsibility for Community Health Record. Effective July 1, 2005, VSHP shall receive all data to be contained in the CHR. VSHP will provide a health maintenance module within the CHR which captures individual progress toward receiving targeted preventive health interventions for their cohort (i.e. EPSDT requirements for children and youth). The module helps clinicians recognize opportunities for educational and preventative healthcare services for their patients at the point of care. VSHP will link all of this data based on an Enterprise Master Person Index (EMPI). The EMPI provides a central repository for person-centric data from a variety of contributing systems. EMPI facilitates the integrity of a single person record. The mission of the EMPI is to provide the functionality for the end-user to find the right person and the right information at the right time. Additionally, the EMPI provides a solution to identify and eliminate as many duplicate records as possible.
- b. Community Health Record Deliverables. Effective July 1, 2005, version 1.0 of the CHR shall be available to TENNCARE for VSHP contracted providers and all enrollees assigned to BlueCare/TennCare Select. Enrollees may opt out in which case the enrollee's information will be omitted from view through the CHR. The CHR shall include the following enrollee information:
 - Patient Demographics
 - Primary Care Physicians (PCPs) identified
 - Claimed visit information from claims detail
 - Medication information from claims detail
 - State immunization information
 - Lab data information from claims detail
 - Interactivity by the provider through EPSDT (TenderCare) documentation to include 16 age specific forms complying with current periodicity
- c. Community Health Record Electronic Prescribing Function

Beginning no later than October 31, 2005, as a component of the Community Health Record function of TennCare Select, the Contractor shall begin making available to VSHP contracted providers the following electronic prescribing functionality to allow for prescribing medications:

- Eligibility
- Formulary information
- Drug to drug compatibility
- Drug to allergy checking
- Dose range checking based on predetermined characteristics including age, height, weight and additional attributes
- Member and provider education as regards co-pays and total costs differentials for brand names versus generic utilization
- Appropriate therapeutic substitution
- Step care progression relevant to clinical process

Effective no later than September 1, 2006, VSHP shall make available the current version of the Community Health Connection to all TennCare providers for the entire TennCare population, with the exception of enrollees who opt out, not to exceed 1.3 million members. Prior to

Further guidance, including but not limited to, timeframes and procedural requirements will be provided in the memorandum of understanding between the State and Shared Health.

d. Cooperation with Regional Health Information Organizations

Consistent with the state's objectives to further electronic community health record efforts more broadly, VSHP and its sub-contractors shall, in keeping with the obligations and goals of this agreement, cooperate with contracted Regional Health Information Organizations as directed by TennCare.

e. Use of Community Health Record Information

The CONTRACTOR agrees that all information, including but not limited to, studies, draft manuscripts, etc., to be used for any other purpose than to fulfill the obligations of this Contract shall be submitted to TENNCARE for review and written, expressed approval prior to its release and/or use.

35 Section 5-1.b., c., i and j shall be deleted in their entirety and replaced by new Sections 5-1.b., c., i and j which shall read as follows:

b. Effective January 1, 2003, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be \$25.00 per member per month. Effective July 1, 2006, the administrative fee paid for enrollees in Group 1.A, Group 1.B and Group 2 shall be \$25.20 per member per month.

c. Effective January 1, 2003, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.37
100,000 to 199,999 enrollees	\$11.25
200,000 to 299,999 enrollees	\$11.12
300,000 to 399,999 enrollees	\$11.00
400,000 to 499,999 enrollees	\$10.89
500,000 to 599,999 enrollees	\$10.68
600,000 to 699,999 enrollees	\$10.53
700,000 to 799,999 enrollees	\$10.38
800,000 to 899,999 enrollees	\$10.23
900,000 to 999,999 enrollees	\$10.08
1,000,000 or more enrollees	\$9.93

Effective July 1, 2006, the administrative fee paid for enrollees in Group 3, Group 4, Group 5 and Group 6 shall vary based on the total number of enrollees in these groups as follows:

Enrollment Level	Administrative Fee
0 to 99,999 enrollees	\$11.57
100,000 to 199,999 enrollees	\$11.45
200,000 to 299,999 enrollees	\$11.32
300,000 to 399,999 enrollees	\$11.20
400,000 to 499,999 enrollees	\$11.09
500,000 to 599,999 enrollees	\$10.88
600,000 to 699,999 enrollees	\$10.73
700,000 to 799,999 enrollees	\$10.58
800,000 to 899,999 enrollees	\$10.43
900,000 to 999,999 enrollees	\$10.28
1,000,000 or more enrollees	\$10.13

800,000 to 899,999 enrollees	\$10.43
900,000 to 999,999 enrollees	\$10.28
1,000,000 or more enrollees	\$10.13

- i. The applicable administrative fee shall be determined based upon the total number of enrollees in the month preceding the month in which payment is made to the Contractor as determined by TENNCARE. The administrative fee specified shall be applicable to all enrollees in Group 3, Group 4, Group 5 and Group 6 upon attainment of an enrollment level. For example, if enrollment for the month of February is 250,000 enrollees, the administrative fee payment for the month of March shall be \$11.12 per member per month for each Group 3, Group 4, Group 5 and Group 6 enrollee assigned to the CONTRACTOR during the month of March, adjusted as set forth in subparagraphs 5-1.d through 5-1.j, if applicable.
- i. Effective July 1, 2005 through August 31, 2006, VSHP shall provide all services required to maintain the CHR, EPSDT documentation and reporting analytics as related to said CHR as defined above, at no additional charge to the TennCare Bureau. Effective September 1, 2006 through June 30, 2007, VSHP shall be reimbursed an administration fee for maintaining and providing the CHR of \$1.20 PMPM for enrollees participating in the CHR.. TENNCARE shall not reimburse the additional \$1.20 PMPM for enrollees who opt out and are omitted from the CHR. Upon sixty (60) calendar days prior written notice, the State may terminate the services to be provided under this section of this agreement with or without cause, and/or for convenience. Upon provision of said notice and at the conclusion of the sixty (60) calendar day notice period VSHP's obligation to provide necessary services to maintain the CHR will end and the State shall have no further obligation to reimburse the \$1.20 PMPM administration fee.
- j. Pay-for-Performance Administrative Fee for Disease Management (DM)
 1. Depending of the level of performance, the CONTRACTOR may earn up to \$0.12 pmpm in the form of a supplemental administrative fee for disease management.

On July 1, 2006, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of July 1, 2005 to June 30, 2006, if their HEDIS 2006 HbA1c testing rate is at or above the 50th percentile for Medicaid HEDIS 2005, as reported by NCQA. In addition, on July 1, 2006, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of July 1, 2005 to June 30, 2006, if their HEDIS 2006 Prenatal Care rate is at or above the 75th percentile for Medicaid HEDIS 2005, as reported by NCQA.

On December 31, 2006, the CONTRACTOR will report the following ED utilization data to TENNCARE:

1. Emergency department visits with a diagnosis of asthma divided by total number of enrollees in the MCO with a diagnosis of asthma, multiplied by 1000 for the time periods July 1 – September 30 in calendar year 2005 and in calendar year 2006.
2. Emergency department visits with a diagnosis of congestive heart failure divided by total number of enrollees in the MCO with a diagnosis of congestive heart failure, multiplied by 1000 for the time periods July 1 – September 30 in calendar year 2005 and in calendar year 2006.

Emergency Department visits shall include all ER visits even if the visit results in a 23 Hour Observation or an inpatient stay. Include Emergency Department visits whether or not an actual payment to the provider was made for the services.

The CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of January 1, 2006 to December 31, 2006, if the ED visit rate per 1000 for asthma has decreased by at least 5% from 2005. Similarly, the CONTRACTOR will be eligible for an additional \$0.03 pmpm, applied to member months from the period of January 1, 2006 to December 31, 2006, if the ED visit rate per 1000 for congestive heart failure has decreased by at least 5% from 2005.

Beginning on July 1, 2007, the supplemental administrative fee will be referred to as a Quality Incentive and will be based on HEDIS, CAHPS and/or utilization criteria specified by TennCare and assessed annually. The CONTRACTOR will be advised of the specific methodology that will be used for the July 1, 2007 supplemental fee determination, by September 1, 2006.

The CONTRACTOR's eligibility for the supplemental administrative fee payment described in this Section shall not adjust the base administrative fee described elsewhere in this Section 5-1 of this Contract for effective dates not described in this Section 5-1.j.

36. Section 5-3.a shall be amended by adding new text so that the amended Section 5-3.a shall read as follows:

- a. Medical Services Payments. The CONTRACTOR shall assure that payments are not issued to providers that have not obtained a Tennessee Medicaid provider number or for which disclosure requirements have not been obtained by the CONTRACTOR in accordance with 42 CFR 455.100 through 106 and Section 2-18 of this Contract. The CONTRACTOR shall prepare checks for payment on a periodic basis. The CONTRACTOR shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 72 hours in advance of distribution of provider checks. The amount to be paid shall be reduced by the amount of third party recoveries captured in the claims processing system. The State shall release funds in the amount to be paid to providers to the CONTRACTOR. Funds shall be released within 72 hours of receipt of notice. In turn, the CONTRACTOR shall release payments to providers within 24 hours of receipt of funds from the State and provide TENNCARE with a check register or similar document that is generated from the managed care claims processing system supporting the release of these payments by no later than seven (7) calendar days after the CONTRACTOR's request of the funds.

For each request related to payments to providers through the CONTRACTOR's claims processing system, the CONTRACTOR shall provide a claims data extract in a format and media described by TENNCARE to support the payments released to providers. The CONTRACTOR should provide a reconciliation for the total paid amounts between the funds released for payment to providers, the supporting claims data extract, and the encounter data submissions for the relevant adjudication cycle. The reconciliation should be submitted within seven (7) days of the claims data extract.

Upon notification by TENNCARE, funds released to the CONTRACTOR for purposes of provider payments shall be made based on the CONTRACTOR's encounter data. TENNCARE shall implement this process by initially making payments based on all encounters and providing the CONTRACTOR an error report of unacceptable encounter records. The final phase of implementation shall result in TENNCARE releasing funds based on clean encounters only. Once TENNCARE releases funds based solely on clean encounter data, the CONTRACTOR will no longer be required to submit the claims data extract. The reconciliation and check register must continue to be submitted on a weekly basis for the previous weeks check release.

The CONTRACTOR shall pursue and report on providers which maintain an accounts-payable balance or maintain outstanding checks in accordance with Section 2-10.1 of this Agreement.

37. Section 6-7 shall be deleted and replaced in its entirety so that the amended Section 6-7 shall read as follows:

6-7. Conflict of Interest

- (a) The CONTRACTOR warrants that no part of the total Contract amount provided herein shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the CONTRACTOR in connection with any work contemplated or performed relative to this Contract unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. The authorization may be requested in writing to the Commissioner of Finance and Administration. (See 45 CFR 93.100 *et seq.*, 31 USC 1352, TCA 3-6-101 *et seq.*, 3-6-201 *et seq.*, 3-6-301 *et seq.*, and 8-50-505.)
- (b) By December 31 of each year disclosure shall be made by the CONTRACTOR to the Deputy Commissioner of the Bureau of TennCare, Department of Finance and Administration in writing. The disclosure shall include the following:
1. A list of any officer or employee of the State of Tennessee who receives wages or compensation in connection with work performed under this Contract;
 2. A statement of the reason or purpose for the wages or compensation; and
 3. A statement that the Commissioner of Department of Finance and Administration has authorized this arrangement.
- (c) This Contract may be terminated by TENNCARE if it is determined that the CONTRACTOR, its agents or employees offered or gave gratuities of any kind to any officials or employees of the State of Tennessee. The CONTRACTOR certifies that no member of or delegate of Congress, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially from this Contract.

The CONTRACTOR shall include the substance of this clause in all subcontracts and provider agreements.

38. The Liquidated Damages chart of Program Issues in Section 6-8.b.2 shall be deleted and replaced in its entirety so that the amended Chart of Liquidated Damages shall read as follows:

CLASS	PROGRAM ISSUES	DAMAGE
A.1	Failure to comply with claims processing as described in Section 2-9.7 of this Agreement	\$10,000 per month, for each month that TENNCARE determines that the CONTRACTOR is not in compliance with the requirements of Section 2-9.7 of this Agreement.
A.2	Failure to comply with licensure requirements in Section 2-9.4 of this Contract	\$5,000 per calendar day that staff/provider/agent/subcontractor is not licensed as required by applicable state law plus the amount paid to the

		staff/provider/agent/subcontractor during that period
A.3	Failure to respond to a request by DCS or TENNCARE to provide service(s) to a child in DCS custody or at risk of entering DCS custody as described in Section 3 of this Agreement	\$1000 per occurrence
A.4	Failure to comply with obligations and timeframes in the delivery of EPSDT screens and related services	\$1000 per occurrence
A.5	Denial of a request for services to a child in DCS custody or at risk of entering DCS custody when the services have been reviewed and authorized by the TENNCARE Chief Medical Officer	\$1000 per occurrence
A.6	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TENNCARE to do so or upon approval of the service or payment by the CONTRACTOR during the appeal process, or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of good cause.	\$500 per day beginning on the next calendar day after default by the plan in addition to the cost of the services not provided.
A.7	Failure to provide proof of compliance to the Bureau Office of Contract Compliance and Performance within five (5) calendar days of a reasonable and appropriate directive from TennCare or within a longer period of time which has been approved by TENNCARE upon a plan's demonstration of Good Cause.	\$500 per day beginning on the next calendar day after default by the plan.
A.8	Failure to comply with this Agreement and federal rules/law regarding Sterilizations/Abortions/Hysterectomies as outlined in Section 2-3.11 of this Agreement	\$500 per violation or the actual amount of the federal penalty created by this violation, whichever is greater.
A.9	Failure to provide coverage for prenatal care without a delay in care and in accordance with the terms of this Agreement	\$500 per day, per occurrence, for each day that care is not provided in accordance with the terms of this Agreement.
A.10	Failure to comply with the notice requirements of the TENNCARE rules and regulations or any	\$500 per occurrence in addition to \$500 per calendar day for each calendar day required notices are late or deficient or

	subsequent amendments thereto, and all court orders governing appeal procedures, as they become effective.	for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Agreement or required by TENNCARE
A.11	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by the TENNCARE rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.	<p>An amount sufficient to at least offset any savings the CONTRACTOR achieved by withholding the services and promptly reimbursing the enrollee for any costs incurred for obtaining the services at the enrollee's expense.</p> <p>\$500 per day for each calendar day beyond the 2nd business day after an On Request Report regarding a member's request for continuation of benefits is sent by TENNCARE.</p>
A.12	Failure to forward an expedited appeal to TENNCARE in twenty-four (24) hours or a standard appeal in five (5) days.	\$500 per calendar day.
A.13	Failure to provide complete documentation, including medical records, and comply with the timelines for responding to a medical appeal as set forth in TennCare rules and regulations and all court orders and consent decrees governing appeals procedures as they become effective.	\$500 per calendar day for each calendar day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this Contract or required by TENNCARE.
A.14	Failure to submit a timely corrected notice of adverse action to TENNCARE for review and approval prior to issuance to the member.	\$1,000 per occurrence if the notice remains defective plus a per calendar day assessment in increasing increments of \$500 (\$500 for the first day, \$1,000 for the second day, \$1,500 for the third day, etc.) for each day the notice is late and/or remains defective.
A.15	Per the Revised Grier Consent Decree, "Systemic problems or violations of the law" (e.g., a failure in 20% or more of appealed cases over a 60-day period) regarding any aspect of medical appeals processing pursuant to TennCare rules and regulations and all court orders and consent decrees governing appeal procedures, as they become effective.	<p>First occurrence: \$500 per instance of such "systemic problems or violations of the law", even if damages regarding one or more particular instances have been assessed (in the case of "systemic problems or violations of the law" relating to notice content requirements, \$500 per notice even if a corrected notice was issued upon request by TENNCARE).</p> <p>Damages per instance shall increase in \$500 increments for each subsequent</p>

		<p>“systemic problem or violation of the law” (\$500 per instance the first time a “systemic problem or violation of the law” relating to a particular requirement is identified; \$1,000 per instance for the 2nd time a “systemic problem or violation of the law” relating to the same requirement is identified; etc.)</p>
A.16	Systemic violations regarding any aspect of the requirements in accordance with this Contract and the TennCare rules and regulations.	<p>First occurrence: \$500 per instance of such systemic violations, even if damages regarding one or more particular instances have been assessed.</p> <p>Damages per instance shall increase in \$500 increments for each subsequent systemic violation (\$500 per instance the first time a systemic violation relating to a particular requirement is identified; \$1,000 per instance for the 2nd time a systemic violation relating to the same requirement is identified; etc.)</p>
A.17	Failure to adhere to ED guidelines as described in Section 2-7.1.e of this Contract.	<p>\$1000 per occurrence for each failure to enroll a member identified per 2-7.1.e in active case management.</p> <p>\$5000 per occurrence for each failure to assist a member in arranging care in an alternative setting per 2-7.1.e (7) or (8).</p>
A.18	Failure to 1) provide an approved service timely, i.e., in accordance with timelines specified in the Special Terms and Conditions for Access in the TennCare Waiver or Attachment III, or when not specified therein, with reasonable promptness; or 2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service.	The cost of services not provided plus \$500 per day, per occurrence, for each day 1) that approved care is not provided timely; or 2) notice of delay is not provided and/or the MCC fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service.
B.1	Failure to report Specialty listings to PCP providers as required by this Agreement	\$500 per calendar day.
B.2	Failure to complete or comply with corrective action plans as required by TENNCARE	\$500 per calendar day for each day the corrective action is not completed or complied with as required.
B.3	Failure to seek, collect and/or report third party recoveries to TENNCARE.	\$500 per day for each calendar day that TENNCARE determines the CONTRACTOR is not making reasonable effort to seek and collect third party recoveries.

B.4	Deadlines for Achieving NCQA Accreditation	Termination of the Agreement for Breach as described in Section 6-2 for consistent failure to meet the deadlines described in Section 2-9.8.7 of this Agreement.
B.5	Failure to submit Audited HEDIS and CAHPS Reports Annually by June 15 th as described in Section 2-9. 8.7 and 2-10.13.4	\$250 per day for every calendar day reports are late.
B.6	Failure to submit NCQA Accreditation Report as described in Sections 2-9.8.7 and 2-10.13.6	\$500 per day for every calendar day beyond the 10 th calendar day Accreditation Status is not reported.
B.7	Failure to comply with Conflict of Interest, Lobbying, and Gratuities requirements described in Section 6-7, 6-11 or 6-12.	110% of the total amount of compensation paid by the CONTRACTOR to inappropriate individuals as described in Section 6-7, 6-11 or 6-12 and possible termination of the Agreement as described in 6-7, 6-11 or 6-12.
B.8	Failure to submit TennCare Disclosure of Lobbying Activities Form by CONTRACTOR	\$1000.00 per day that disclosure is late
B.9	Failure to comply with Offer of Gratuities constraints described in Section 6-11	110 % of the total benefit provided by the CONTRACTOR to inappropriate individuals and possible termination of the Agreement for Breach as described in 6-2 of this Agreement.
B.10	Failure to obtain approval of Marketing Materials.	\$500 per day for each calendar day that TENNCARE determines the CONTRACTOR has provided enrollee material that has not been approved by TENNCARE.
B.11	Failure to comply with Marketing timeframes for providing Member Handbooks, I.D. cards, Provider Directories, and Newsletters.	\$5000 for each occurrence.
B.12	Failure to achieve and/or maintain financial reserves in accordance with TCA.	\$500 per calendar day for each day that financial requirements have not been met.
B.13	Failure to submit the CONTRACTOR's annual NAIC filing as described in Section 2.10.8.	\$500 per calendar day.
B.14	Failure to submit the CONTRACTOR's quarterly NAIC filing as described in Section 2.10.8.	\$500 per calendar day.
B.15	Failure to submit audited financial statements as described in Section 2.10.8.	\$500 per calendar day.
B.16	Failure to comply with fraud and abuse provisions as described in Section 2-9.13 of this Contract.	\$500 per calendar day for each day that the CONTRACTOR does not comply with fraud and abuse provisions

		described in Section 2-9.13 of this Contract.
B.17	Failure to send collection notices to providers as described in 2-10.5.3(a) of this Agreement.	\$100 per provider notice per month.
B.18	Failure to send detailed reports to TENNCARE as described in 2-10.5.3(b), (c) and (d) of this Contract.	\$500 per day for each day that report is late.
B.19	Failure to require and assure compliance with Ownership and Disclosure requirements.	\$5000 per provider disclosure/attestation for each disclosure/attestation that is not received or is received and signed by a provider that does not request or contain complete and satisfactory disclosure of the requirements outlined in 42 CFR 455, Subpart B.
B.20	Failure to maintain a complaint and appeal system as required in Section 2-8 of this Contract.	\$500 per calendar day
B.21	Failure to maintain required insurance as required in Section 2-20 of this Contract.	\$500 per calendar day
B.22	Imposing arbitrary utilization guidelines or other quantitative coverage limits as prohibited in Section 2-3.3 and 2-7.1 of this Contract.	\$500 per occurrence.
B.23	Failure to completely process a credentialing application within thirty (30) calendar days of receipt of a completed, including all necessary documentation and attachments, credentialing application as required in Section 2-4.7.6 and 2-9.8.6 of this Contract.	<p>\$5000 per application that has not been approved and loaded into the CONTRACTOR's system or denied within thirty (30) calendar days of receipt of a completed credentialing application.</p> <p>And/Or</p> <p>\$1000 per application per day for each day beyond thirty (30) calendar days that a completed credentialing application has not been completed as described in Section 2-3.k.6 and 2-9.j.6 of this Contract.</p>
B.24	Failure to maintain provider agreements in accordance with Section 2-18 of this Contract.	\$5000 per provider agreement found to be non-compliant with the requirements outlined in Section 2-18 of this Contract.
C.1	Failure to comply in any way with staffing requirements as described in Section 2-9 of this Agreement	\$250 per calendar day for each day that staffing requirements as described in Section 2-9 of this Agreement are not met.
C.2	Failure to report provider notice of	\$200 per day.

	termination of participation in the CONTRACTOR's plan	
C.3	Failure to address or resolve problems with individual encounter records in a timely manner as required by TENNCARE.	An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TENNCARE.

39. Section 6-12 shall be deleted and replaced in its entirety so that the amended Section 6-12 shall read as follows:

6-12. Lobbying

The CONTRACTOR certifies by signing this Contract, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. (See also TCA 3-6-101 *et seq.*, 3-6-201 *et seq.*, 3-6-301 *et seq.*, and 8-50-505.).

The CONTRACTOR shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

Failure by the Contractor to comply with the provisions herein shall result in termination of the Contract and/or liquidated damages as provided in 6-8.b.2 (B.7, B.8 and B.9) of this Contract.

40. Attachment II shall be deleted in its entirety and shall now read "Left Blank Intentionally".
41. Attachment XII, Exhibit C shall be deleted and replaced in its entirety and shall read as follows:

ATTACHMENT XII, EXHIBIT C REQUIRED DATA ELEMENTS FOR PROVIDER ENROLLMENT REPORTING

This provider listing shall include, at a minimum, the following data elements:

1. Provider name;
2. Provider address, including the address of all service sites operated by the provider (a P.O. Box is not acceptable);
3. Tax/Employer I.D. number (EIN) or Provider social security;
4. Provider's race and/or national origin;
5. Provider Specialty 1 and Specialty 2;
6. Provider license number and type of license (if applicable);
7. Tennessee Medicaid Provider I.D. Number for the individual provider being enrolled (Should correspond to the Provider Name) .;
8. Unique Individual MCC Provider I.D. Number (Should correspond to the Provider Name);
9. Medicare I.D. number, if applicable (Should correspond to the Provider Name);

10. Initial Credentialing Date;
11. Recredentialing Date (This date must reflect the actual date recredentialing completed);
12. Provider telephone number (including area code) for each provider service site (up to 6 phone numbers);
13. Provider's Drug Enforcement Agency (DEA) number (if applicable);
14. Begin date of participation and end date of participation (if applicable);
15. Contracted Provider versus Non-Contracted Provider Indicator (single case agreements are considered Non-Contracted Providers);
16. Indicate whether or not the following services are provided by the provider: Obstetrics, General Surgery, Pediatrics, or EPSDT;
- 17.. Is the provider board certified;
18. The provider's service delivery county of practice; and
19. Indicate whether or not the provider's practice is limited to male or female patients;
20. Date disclosure form/attestation signed by provider;

For Dentists and Primary Care Providers (PCP) the following additional data elements are required:

21. Is the Dental / PCP's practice closed to new TennCare members as primary care patients;

For Primary Care Providers (PCPs only) the following additional data elements are required:

22. Does the PCP deliver babies;
 23. Does the PCP provide prenatal care;
 24. What is the youngest age each individual PCP will accept as a patient into the PCP's practice? (Age zero (00) equates to providing services to newborns);
 25. What is the oldest age each individual PCP will accept as a patient into the PCP's practice? (Age 99 equates to Age 99 and older); and
 26. How many members has the MCO assigned to each individual PCP for primary care service delivery?
42. Attachment XII, Exhibits L.1 through L.3 shall be amended by deleting the words "Cumulative Year to Date" from the Header of each reporting format.
 43. This Contract shall be amended by deleting the words "Office of Contract Development and Compliance (OCDC) and replacing them with "Office of Contract Compliance and Performance (OCCP)".

All of the provisions of the original Contract not specifically deleted or modified herein shall remain in full force and effect. Unless a provision contained in this Amendment specifically indicates a different effective date, for purposes of the provisions contained herein, this Amendment shall become effective July 1, 2006 or as of the date it is approved by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

IN WITNESS WHEREOF, the parties have by their duly authorized representatives set their signatures.

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

VOLUNTEER STATE HEALTH PLAN, INC.

BY: _____
M. D. Goetz, Jr.
Commissioner

BY: _____
Ronald E. Harr
President and Chief Executive Officer

DATE: _____

DATE: _____

APPROVED BY:

APPROVED BY:

**STATE OF TENNESSEE
DEPARTMENT OF FINANCE
AND ADMINISTRATION**

**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

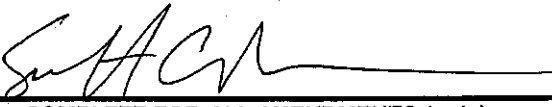
BY: _____
M. D. Goetz, Jr.
Commissioner

BY: _____
John G. Morgan
Comptroller


DATE: _____

DATE: _____

CONTRACT SUMMARY SHEET

RFS Number: 318.66-026		Contract Number: FA-02-14632-14	
State Agency: Department of Finance and Administration		Division: Bureau of TennCare	
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V- <input type="checkbox"/> C-	
Service Description			
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population			
Contract Begin Date		Contract End Date	
7/1/2001		12/31/2006	
Allotment Code	Cost Center	Object Code	Fund
318.66	532	134	11
		<input type="checkbox"/> STARS	
FY	State Funds	Federal Funds	Interdepartmental Funds
2002	\$ 6,755,937.23	\$ 11,843,931.25	
2003	\$ 15,785,123.40	\$ 17,294,819.40	
2004	\$ 25,125,990.72	\$ 38,364,165.90	
2005	\$ 58,007,447.00	\$ 58,007,447.00	
2006	\$87,748,111.00	\$87,748,111.00	
2007	\$29,003,723.50	\$29,003,723.50	
Total:	\$222,426,332.85	\$ 242,262,198.05	
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.		Check the box ONLY if the answer is YES:
State Fiscal Contract			Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Name:	Scott Pierce	310	Is the Contractor a Vendor? (per OMB A-133)
Address:	Great Circle Road		Is the Fiscal Year Funding STRICTLY LIMITED?
Phone:	Nashville, TN (615)507-6415		Is the Contractor on STARS?
Procuring Agency Budget Officer Approval Signature			Is the Contractor's FORM W-9 ATTACHED?
Scott Pierce 			Is the Contractor's Form W-9 Filed with Accounts?
COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:	12/31/2006		
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$116,014,894.00		
FY: 2006	\$172,434,996.00	\$3,061,226.00	
FY: 2007	\$58,007,447.00		
Total:	\$ 461,627,304.90	\$3,061,226.00	

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026			Contract Number:	FA-02-14632-13		
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare		
Contractor				Contract Identification Number			
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-			
Service Description							
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population							
Contract Begin Date				Contract End Date			
7/1/2001				12/31/2006			
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code	
318.66	532	134	11	<input type="checkbox"/> STARS			
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)		
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48		
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80		
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62		
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00		
2006	\$86,217,498.00	\$86,217,498.00			\$172,434,996.00		
2007	\$29,003,723.50	\$29,003,723.50			\$58,007,447.00		
Total:	\$ 220,895,719.85	\$ 240,731,585.05			\$ 461,627,304.90		
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.			Check the box ONLY if the answer is YES:			
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)			
Name:	Scott Pierce 310			Is the Contractor a Vendor? (per OMB A-133)			
Address:	Great Circle Road			Is the Fiscal Year Funding STRICTLY LIMITED?			
Phone:	Nashville, TN (615)507-6415			Is the Contractor on STARS?			
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?			
Scott Pierce 				Is the Contractor's Form W-9 Filed with Accounts?			
COMPLETE FOR ALL AMENDMENTS (only)				Funding Certification			
		Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.			
CONTRACT END DATE:		12/31/2006					
FY: 2002		\$ 18,599,868.48					
FY: 2003		\$ 33,079,942.80					
FY: 2004		\$ 63,490,156.62					
FY: 2005		\$116,014,894.00					
FY: 2006		\$116,014,894.00	\$56,420,102.00				
FY: 2007		\$58,007,447.00					
Total:		\$ 405,207,202.90	\$56,420,102.00				

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 COMPTROLLER'S OFFICE
 OFFICE OF
 MANAGEMENT SERVICES

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026			Contract Number:	FA-02-14632-12	
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare	
Contractor				Contract Identification Number		
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-		
Service Description						
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population						
Contract Begin Date				Contract End Date		
7/1/2001				12/31/2006		
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	532	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62	
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00	
2006	\$58,007,447.00	\$58,007,447.00			\$116,014,894.00	
2007	\$29,003,723.50	\$29,003,723.50			\$58,007,447.00	
Total:	\$ 192,685,668.85	\$ 212,521,534.05			\$ 405,207,202.90	
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.			Check the box ONLY if the answer is YES:		
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)		
Name:	Scott Pierce 310			Is the Contractor a Vendor? (per OMB A-133)		
Address:	Great Circle Road			Is the Fiscal Year Funding STRICTLY LIMITED?		
Phone:	Nashville, TN (615)507-6415			Is the Contractor on STARS?		
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?		
Scott Pierce				Is the Contractor's Form W-9 Filed with Accounts?		
COMPLETE FOR ALL AMENDMENTS (only)				Funding Certification		
	Base Contract & Prior Amendments	This Amendment ONLY		Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.		
CONTRACT END DATE:	12/31/2005	12/31/2006				
FY: 2002	\$ 18,599,868.48					
FY: 2003	\$ 33,079,942.80					
FY: 2004	\$ 63,490,156.62					
FY: 2005	\$116,014,894.00					
FY: 2006	\$55,335,500.00	\$60,679,394.00				
FY: 2007		\$58,007,447.00				
Total:	\$ 286,520,361.90	\$118,686,841.00				

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026			Contract Number:	FA-02-14632-11		
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare		
Contractor				Contract Identification Number			
VSHP (TennCare Select)				<input type="checkbox"/> V-			
<input type="checkbox"/> C-							
Service Description							
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population							
Contract Begin Date				Contract End Date			
7/1/2001				12/31/2005			
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code	
318.66	532	134	11	<input type="checkbox"/> STARS			
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)		
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48		
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80		
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62		
2005	\$ 58,007,447.00	\$ 58,007,447.00			\$ 116,014,894.00		
2006	\$ 27,667,750.00	\$ 27,667,750.00			\$ 55,335,500.00		
Total:	\$ 133,342,248.35	\$ 153,178,113.55			\$ 286,520,361.90		
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.			Check the box ONLY if the answer is YES:			
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)			
Name:	Dean Daniel			Is the Contractor a Vendor? (per OMB A-133)			
Address:	729 Church Street			Is the Fiscal Year Funding STRICTLY LIMITED?			
Phone:	Nashville, TN (615)532-1362			Is the Contractor on STARS?			
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?			
Scott Pierce				Is the Contractor's Form W-9 Filed with Accounts?			
COMPLETE FOR ALL AMENDMENTS (only)				Funding Certification			
		Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.			
CONTRACT END DATE:		12/31/2005					
FY: 2002	\$	18,599,868.48					
FY: 2003	\$	33,079,942.80					
FY: 2004	\$	63,490,156.62					
FY: 2005	\$	116,014,894.00					
FY: 2006	\$	55,335,500.00					
Total:		\$	286,520,361.90				


CONTRACT SUMMARY SHEET

RFS Number:	318.66-026	Contract Number:	FA-02-14632-10		
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare		
Contractor		Contract Identification Number			
VSHP (TennCare Select)		<input type="checkbox"/> V- <input type="checkbox"/> C-			
Service Description					
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population					
Contract Begin Date			Contract End Date		
7/1/2001			12/31/2005		
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code
318.66	532	134	11	<input type="checkbox"/> STARS	
			Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
FY	State Funds	Federal Funds			
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62
2005	\$ 58,007,443.00	\$ 58,007,443.00			\$ 116,014,886.00
2006	\$ 27,667,750.00	\$ 27,667,750.00			\$ 55,335,500.00
Total:	\$ 133,342,244.35	\$ 153,178,109.55			\$ 286,520,353.90
CFDA#	93.778 Title XIX Dept. of Health & Human Svcs.		Check the box ONLY if the answer is YES:		
State Fiscal Contract			Is the Contractor a SUBRECIPIENT? (per OMB A-133)		
Name: Dean Daniel			Is the Contractor a Vendor? (per OMB A-133)		
Address: 729 Church Street			Is the Fiscal Year Funding STRICTLY LIMITED?		
Phone: Nashville, TN			Is the Contractor on STARS?		
(615)532-1362			Is the Contractor's FORM W-9 ATTACHED?		
Procuring Agency Budget Officer Approval Signature			Is the Contractor's Form W-9 Filed with Accounts?		
Scott Pierce			Funding Certification		
COMPLETE FOR ALL AMENDMENTS (only)			Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.		
		Base Contract & Prior Amendments	This Amendment ONLY		
CONTRACT END DATE:		12/31/2004	12/31/2005		
FY: 2002		\$ 18,599,868.48			
FY: 2003		\$ 33,079,942.80			
FY: 2004		\$ 63,490,156.62			
FY: 2005		\$ 110,671,000.00	\$ 5,343,886.00		
FY: 2006		\$ 55,335,500.00			
Total:	\$ 281,176,467.90	\$ 5,343,886.00			

CONTRACT SUMMARY SHEET

RFS Number: 318.66-026		Contract Number: FA-02-14632-09	
State Agency: Department of Finance and Administration		Division: Bureau of TennCare	
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V. <input type="checkbox"/> C-	
Service Description			
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population			
Contract Begin Date		Contract End Date	
7/1/2001		12/31/2005	
Allotment Code	Cost Center	Object Code	Fund
318.66	532	134	11
		<input type="checkbox"/> STARS <input type="checkbox"/> Other Funding	
		Total Contract Amount (including ALL amendments)	
FY	State Funds	Federal Funds	
2002	\$ 6,755,937.23	\$ 11,843,931.25	\$ 18,599,868.48
2003	\$ 15,785,123.40	\$ 17,294,819.40	\$ 33,079,942.80
2004	\$ 25,125,990.72	\$ 38,364,166.90	\$ 63,490,156.62
2005	\$ 55,335,500.00	\$ 55,335,500.00	\$ 110,671,000.00
2006	\$ 26,667,750.00	\$ 26,667,750.00	\$ 55,335,500.00
Total:	\$ 129,670,301.35	\$ 149,508,166.55	\$ 281,178,467.90
CFDA# 93.778			
State Fiscal Contract		Check the box ONLY if the answer is YES:	
Name: Dean Daniel	Is the Contractor a SUBRECIPIENT? (per OMB A-133)		
Address: 729 Church Street	Is the Contractor a Vendor? (per OMB A-133)		
Phone: Nashville, TN (615)532-1362	Is the Fiscal Year Funding STRICTLY LIMITED?		
Procuring Agency Budget Officer Approval Signature	Is the Contractor on STARS?		
Scott Pierce	Is the Contractor's FORM W-9 ATTACHED?		
	Is the Contractor's Form W-9 Filed with Accounts?		
Funding Certification			
Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.			
COMPLETE FOR ALL AMENDMENTS (only)			
	Base Contract & Prior Amendments	This Amendment ONLY	
CONTRACT END DATE:	12/31/2004	12/31/2005	
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 63,490,156.62		
FY: 2005	\$ 39,155,080.00	\$ 71,515,920.00	
FY: 2006	\$ 55,335,500.00	\$ 55,335,500.00	
Total:	\$ 154,325,047.90	\$ 126,851,420.00	

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026			Contract Number:	FA-02-14632-08		
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare		
Contractor				Contract Identification Number			
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-			
Service Description							
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population							
Contract Begin Date				Contract End Date			
7/1/2001				12/31/2004			
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code	
318.66	532	134	11	<input type="checkbox"/> STARS			
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)		
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48		
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80		
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62		
2005	\$ 13,935,109.85	\$ 25,219,978.15			\$ 39,155,088.00		
Total:	\$ 61,602,161.20	\$ 92,722,894.70			\$ 154,325,055.90		
CFDA#	93.778			Check the box ONLY if the answer is YES:			
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)			
Name:	Dean Daniel			Is the Contractor a Vendor? (per OMB A-133)			
Address:	729 Church Street						
Phone:	Nashville, TN (615)532-1362			Is the Fiscal Year Funding STRICTLY LIMITED?			
Procuring Agency Budget Officer Approval Signature				Is the Contractor on STARS?			
Scott Pierce				Is the Contractor's FORM W-9 ATTACHED?			
				Is the Contractor's Form W-9 Filed with Accounts?			
COMPLETE FOR ALL AMENDMENTS (only)				Funding Certification			
		Base Contract & Prior Amendments	This Amendment ONLY		Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.		
CONTRACT END DATE:							
FY: 2002	\$ 18,599,868.48						
FY: 2003	\$ 33,079,942.80						
FY: 2004	\$ 63,490,156.62						
FY: 2005	\$ 34,094,974.00	\$ 5,060,114.00					
FY:							
Total:	\$ 149,264,941.90	\$ 5,060,114.00					

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CONTRACT SUMMARY SHEET

RFS Number:	318.66-026			Contract Number:	FA-02-14632-07		
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare		
Contractor				Contract Identification Number:			
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-			
Service Description							
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population							
Contract Begin Date				Contract End Date			
7/1/2001				12/31/2004			
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code	
318.66	532	134	11	<input type="checkbox"/> STARS			
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)		
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48		
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80		
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62		
2005	\$ 12,121,615.63	\$ 21,973,358.37			\$ 34,094,974.00		
Total:	\$ 59,788,666.98	\$ 89,476,274.92			\$ 149,264,941.90		
CFDA#	93.778			Check the box ONLY if the answer is YES:			
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)			
Name:	Dean Daniel			Is the Contractor a Vendor? (per OMB A-133)			
Address:	729 Church Street			Is the Fiscal Year Funding STRICTLY LIMITED?			
Phone:	Nashville, TN (615)532-1362			Is the Contractor on STARS?			
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?			
Dean Daniel <i>Dean Daniel 6/24/04</i>				Is the Contractor's Form W-9 Filed with Accounts?			
Funding Certification							
COMPLETE FOR ALL AMENDMENTS (only)				Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.			
	Base Contract & Prior Amendments		This Amendment ONLY				
CONTRACT END DATE:							
FY: 2002	\$ 18,599,868.48						
FY: 2003	\$ 33,079,942.80						
FY: 2004	\$ 63,490,156.62						
FY: 2005	\$ 34,094,974.00						
FY:							
Total:		\$ 149,264,941.90	\$ -				

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CONTRACT SUMMARY SHEET

RFS Number:	318.66-026			Contract Number:	FA-02-14632-06		
State Agency:	Department of Finance and Administration			Division:	Bureau of Tenn Care		
Contractor				Contract Identification Number			
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-			
Service Description							
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population							
Contract Begin Date				Contract End Date			
7/1/2001				12/31/2004			
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code	
318.66	839	134	11	<input type="checkbox"/> STARS			
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)		
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48		
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80		
2004	\$ 25,125,990.72	\$ 38,364,165.90			\$ 63,490,156.62		
2005	\$ 12,121,615.63	\$ 21,973,358.37			\$ 34,094,974.00		
Total:	\$ 59,788,666.98	\$ 89,476,274.92			\$ 149,264,941.90		
CFDA#	93.778			Check the box ONLY if the answer is YES:			
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)			
Name: Dean Daniel				Is the Contractor a Vendor? (per OMB A-133)			
Address: 729 Church Street				Is the Fiscal Year Funding STRICTLY LIMITED?			
Phone: Nashville, TN (615)532-1362				Is the Contractor on STARS?			
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?			
Dean Daniel <i>Dean Daniel</i> 12/23/03				Is the Contractor's Form W-9 Filed with Accounts?			
COMPLETE FOR ALL AMENDMENTS (only)				Funding Certification			
		Base Contract & Prior Amendments	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.				
CONTRACT END DATE:							
FY: 2002		\$ 18,599,868.48					
FY: 2003		\$ 33,079,942.80					
FY: 2004		\$ 29,395,182.62	\$ 34,094,974.00				
FY: 2005			\$ 34,094,974.00				
FY:							
Total:	\$ 81,074,993.90	\$ 68,189,948.00					

STOP! DO NOT SIGN
 THIS CONTRACT WITHOUT
 THE SIGNATURE OF THE
 COMMISSIONER OF FINANCE
 AND ADMINISTRATION
 DATE 12-23-03

CONTRACT SUMMARY SHEET

RFS Number:	318.66-026			Contract Number:	FA-02-14632-05		
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare		
Contractor				Contract Identification Number			
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-			
Service Description							
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population							
Contract Begin Date				Contract End Date			
7/1/2001				12/31/2003			
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code	
318.66	839	134	11	<input type="checkbox"/> STARS			
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)		
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48		
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80		
2004	\$ 13,004,375.09	\$ 16,390,807.53			\$ 29,395,182.62		
Total:					\$ 81,074,993.90		
CFDA#	93.778			Check the box ONLY if the answer is YES:			
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)			
Name: Dean Daniel				Is the Contractor a Vendor? (per OMB A-133)			
Address: 729 Church Street				Is the Fiscal Year Funding STRICTLY LIMITED?			
Phone: Nashville, TN (615)532-1362				Is the Contractor on STARS?			
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?			
Dean Daniel <i>Dean Daniel</i> 12/11/03				Is the Contractor's Form W-9 Filed with Accounts?			
COMPLETE FOR ALL AMENDMENTS (only)							
		Base Contract & Prior Amendments	This Amendment ONLY				
CONTRACT END DATE:							
FY: 2002		\$ 18,599,868.48					
FY: 2003		\$ 33,079,942.80					
FY: 2004		\$ 24,372,429.50	\$ 5,022,753.12				
FY:							
FY:							
Total:		\$ 76,052,240.78	\$ 5,022,753.12				
Funding Certification							
Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.							
<i>Budget 12-9-03</i>							

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CONTRACT SUMMARY SHEET

RFS Number:	318.66 - 026	Contract Number:	FA-02-14632-04
State Agency:	Department of Finance and Administration	Division:	Bureau of TennCare
Contractor		Contract Identification Number	
VSHP (TennCare Select)		<input type="checkbox"/> V- <input type="checkbox"/> C-	

Service Description
 Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date	Contract End Date
7/1/2001	12/31/2003

Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 11,153,919.98	\$ 13,218,509.53			\$ 24,372,429.50	
Total:		\$ 33,694,980.61	\$ 42,357,260.18		\$ 76,052,240.78	

CFDA# 93.778 Check the box ONLY if the answer is YES:

State Fiscal Contract		Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name:	Dean Daniel	Is the Contractor a Vendor? (per OMB A-133)	
Address:	729 Church Street	Is the Fiscal Year Funding STRICTLY LIMITED?	
Phone:	Nashville, TN (615)532-1362	Is the Contractor on STARS?	
Procuring Agency Budget Officer Approval Signature		Is the Contractor's FORM W-9 ATTACHED?	
Dean Daniel <i>Dean Daniel</i> 11/14/03		Is the Contractor's Form W-9 Filed with Accounts?	

COMPLETE FOR ALL AMENDMENTS (only)			Funding Certification
	Base Contract & Prior Amendments	This Amendment ONLY	Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.
CONTRACT END DATE:			
FY: 2002	\$ 18,599,868.48		
FY: 2003	\$ 33,079,942.80		
FY: 2004	\$ 18,366,944.50	\$ 6,005,485.00	
FY:			
FY:			
Total:	\$ 70,046,755.78	\$ 6,005,485.00	

CONTRACT SUMMARY SHEET

RFS Number:	318-66-026			Contract Number:	FA-02-14632-03	
State Agency:	Department of Finance and Administration			Division:	Bureau of TennCare	
Contractor				Contract Identification Number		
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-		
Service Description						
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population						
Contract Begin Date				Contract End Date		
7/1/2001				12/31/2003		
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> STARS		
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)	
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48	
2003	\$ 15,785,123.40	\$ 17,294,819.40			\$ 33,079,942.80	
2004	\$ 9,183,472.25	\$ 9,183,472.25			\$ 18,366,944.50	
Total:	\$ 31,724,532.88	\$ 38,322,222.90			\$ 70,046,755.78	
CFDA#	93.778			Check the box ONLY if the answer is YES:		
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)		
Name:	Dean Daniel			Is the Contractor a Vendor? (per OMB A-133)		
Address:	729 Church Street			Is the Fiscal Year Funding STRICTLY LIMITED?		
Phone:	(615)532-1362			Is the Contractor on STARS?		
Procuring Agency Budget Officer Approval Signature				Is the Contractor's FORM W-9 ATTACHED?		
Dean Daniel <i>Dean Daniel</i> 6/30/03				Is the Contractor's Form W-9 Filed with Accounts?		
Funding Certification						
COMPLETE FOR ALL AMENDMENTS (only)				Pursuant to T.C.A., Section 9-6-113, I, M. D. Goetz, Jr., Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.		
	Base Contract & Prior Amendments		This Amendment ONLY			
CONTRACT END DATE:						
FY: 2002						
FY: 2003						
FY: 2004						
FY:						
FY:						
Total:	\$	-	\$	-		

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CONTRACT SUMMARY SHEET

Contract Number: FA-02-14632-02	Contract Number: 318.66-026
Division: Bureau of TennCare	Agency: Department of Finance and Administration
Contract Identification Number	
Contractor	
TennCare Select)	

Service Description

Medicaid Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population

Contract Begin Date 7/1/2001	Contract End Date 12/31/2003
---------------------------------	---------------------------------

Contract Code	Cost Center	Object Code	Fund	Grant	Grant Code	Subgrant Code
318.66	839	134	11	<input type="checkbox"/> STARS		
				<input type="checkbox"/> Other Funding		
					Total Contract Amount (including ALL amendments)	
						\$ 18,599,868.48
						\$ 33,079,942.80
						\$ 18,366,944.50
						\$ 70,046,755.78
Total:		\$ 31,724,532.88	\$ 38,322,222.90			

DA#	93.778
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State Fiscal Contract	Is the Contractor a SUBRECIPIENT? (per OMB A-133)
Dean Daniel 729 Church Street Nashville, TN (615)532-1362	Is the Contractor a Vendor? (per OMB A-133)
	Is the Fiscal Year Funding STRICTLY LIMITED?
Procuring Agency Budget Officer Approval Signature	Is the Contractor on STARS?
Daniel <i>Dean Daniel</i>	Is the Contractor's FORM W-9 ATTACHED?
	Is the Contractor's Form W-9 Filed with Accounts?


COMPLETE FOR ALL AMENDMENTS (only)		
	Base Contract & Prior Amendments	This Amendment ONLY
CONTRACT END DATE:	12/31/2003	
002	\$ 18,599,868.48	
003	\$ 28,036,976.80	\$ 5,042,966.00
004	\$ 18,366,944.50	
Total:	\$ 65,003,789.78	\$ 5,042,966.00

Funding Certification

Pursuant to T.C.A., Section 9-6-113, I, C. Warren Neel, Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.

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CONTRACT SUMMARY SHEET

RFS Number: 318.46-026				Contract Number: FA-02-14632-01	
State Agency: Department of Finance and Administration				Division: Bureau of TennCare	
Contractor				Contract Identification Number	
VSHP (TennCare Select)				<input type="checkbox"/> V- <input type="checkbox"/> C-	
Service Description					
Managed Care Organization Services (ASO) / Medically necessary Health Care Services to the TennCare / Medicaid Population					
Contract Begin Date				Contract End Date	
7/1/2001				12/31/2003	
Allotment Code	Cost Center	Object Code	Fund	Grant	Grant Code
318.66	839	134	11	<input type="checkbox"/> STARS	
FY	State Funds	Federal Funds	Interdepartmental Funds	Other Funding	Total Contract Amount (including ALL amendments)
2002	\$ 6,755,937.23	\$ 11,843,931.25			\$ 18,599,868.48
2003	\$ 14,018,488.40	\$ 14,018,488.40			\$ 28,036,976.80
2004	\$ 9,183,472.25	\$ 9,183,472.25			\$ 18,366,944.50
Total:	\$ 29,957,897.88	\$ 35,045,891.90			\$ 65,003,789.78
CFDA#	93.778			Check the box ONLY if the answer is YES:	
State Fiscal Contract				Is the Contractor a SUBRECIPIENT? (per OMB A-133)	
Name: Dean Daniel				Is the Contractor a Vendor? (per OMB A-133)	
Address: 729 Church Street					
Phone: Nashville, TN				Is the Fiscal Year Funding STRICTLY LIMITED?	
(615)532-1362					
Procuring Agency Budget Officer Approval Signature				Is the Contractor on STARS?	
Dean Daniel 				Is the Contractor's FORM W-9 ATTACHED?	
				Is the Contractor's Form W-9 Filed with Accounts?	
COMPLETE FOR ALL AMENDMENTS (only)					
	Base Contract & Prior Amendments	This Amendment ONLY			
CONTRACT END DATE:	12/31/2002	12/31/2003			
FY: 2002	\$ 18,599,868.48				
FY: 2003	\$ 9,670,032.30	\$ 18,366,944.50			
FY: 2004		\$ 18,366,944.50			
FY:					
FY:					
Total:	\$ 28,269,900.78	\$ 36,733,889.00			
Funding Certification					
Pursuant to T.C.A., Section 9-6-113, I, C. Warren Neel, Commissioner of Finance and Administration, do hereby certify that there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred.					

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